



**FAMILY HISTORY:** (Have mother, father, grandparents, brothers or sisters been treated in the past or are currently receiving treatment for any of the following conditions?)

Cancer     Diabetes     Heart Disease     Tuberculosis     Kidney Disease     Arthritis  
 None of these     Other (specify) \_\_\_\_\_

**PLEASE LIST HEALTH STATUS OR CAUSE OF DEATH FOR THE FOLLOWING FAMILY MEMBERS**

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed  
 ( ) Employed - occupation \_\_\_\_\_ ( ) Work in home ( ) Student ( ) Retired  
 Children? ( ) No ( ) Yes - # \_\_\_\_\_ Do you live alone? ( ) No ( ) Yes  
 Smoke Currently? ( ) No ( ) Yes \_\_\_\_\_ # Packs per day for \_\_\_\_\_ years.  
 Do you consume alcohol products? ( ) No ( ) Yes if yes, amount and frequency \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please mark the following symptoms you have experienced on a regular basis

<b>GENERAL</b>	<b>EYES</b>	<b>THROAT</b>	<b>GASTROINTESTINAL</b>
<input type="checkbox"/> fever	<input type="checkbox"/> blurring	<input type="checkbox"/> soreness	<input type="checkbox"/> nausea
<input type="checkbox"/> night sweats	<input type="checkbox"/> eyestrain	<input type="checkbox"/> hoarseness	<input type="checkbox"/> vomiting
<input type="checkbox"/> weight gain	<input type="checkbox"/> glasses/contacts	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> belching
<input type="checkbox"/> weight loss	<input type="checkbox"/> discharge		<input type="checkbox"/> diarrhea
<b>SKIN</b>	<b>EARS</b>	<b>GENITOURINARY</b>	<b>NEUROMUSCULAR</b>
<input type="checkbox"/> eruptions/rashes	<input type="checkbox"/> deafness	<input type="checkbox"/> pain	<input type="checkbox"/> weakness
<input type="checkbox"/> cyanosis (bluish tint)	<input type="checkbox"/> ringing in ears	<input type="checkbox"/> frequent urination	<input type="checkbox"/> joint pain
<input type="checkbox"/> jaundice (yellow tint)	<input type="checkbox"/> pain	<input type="checkbox"/> incontinence	<input type="checkbox"/> tingling
	<input type="checkbox"/> discharge		<input type="checkbox"/> varicosity
			<input type="checkbox"/> deformities
<b>HEAD</b>	<b>NOSE</b>	<b>CARDIOVASCULAR</b>	<b>RESPIRATORY</b>
<input type="checkbox"/> headache	<input type="checkbox"/> sinusitis	<input type="checkbox"/> chest pain	<input type="checkbox"/> chest pain
<input type="checkbox"/> fainting/blackouts	<input type="checkbox"/> obstruction	<input type="checkbox"/> rapid or throbbing heartbeat	<input type="checkbox"/> difficulty breathing
<input type="checkbox"/> trauma		<input type="checkbox"/> faintness	<input type="checkbox"/> bloody sputum
		<input type="checkbox"/> fluid/swelling in extremities	Date of last chest x-ray: _____

**FEMALE REPRODUCTIVE:**  
 Are you or could you be pregnant? ( ) No ( ) Yes

**MEDICATIONS:** Please list all medications you take with or without a prescription (use additional paper if needed)

Medication Name	Dosage / #per day	Reason you take this	Any side effects

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_, M.D. Date: \_\_\_\_\_

Annual update (to be completed after 1 year): There are **NO CHANGES** to the above information in my medical history.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_