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Patient Name: _____ DOB: _____

Please list below any medical condition during the past 10 years which required hospitalization or treatment for a period of more than 2 weeks;

_____

_____

Have you ever been treated for a traumatic injury? ❒ Yes ❒ No

If yes, please specify:

Type of injury	Year	How injury occurred
_____		
_____		

FAMILY HISTORY

Please indicate if a family member has any of the following:

Hypertension	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No
High Cholesterol	❒ Yes	❒ No
Cancer (Type) _____	❒ Yes	❒ No
Stroke	❒ Yes	❒ No
Heart Disease	❒ Yes	❒ No
Depression	❒ Yes	❒ No
Other (Specify) _____	❒ Yes	❒ No

SOCIAL HISTORY

Occupation: _____

Married: ❒ Yes ❒ No

Have you traveled outside the U.S.? ❒ Yes ❒ No

Where? _____ Year _____

LIFESTYLE

Do you or did you smoke? ❒ Yes ❒ No

How many packs per day? _____ How long? _____

When did you quit? _____

Do you drink alcohol? ❒ Yes ❒ No

How often? _____

Have you ever used or are you currently using drugs? ❒ Yes ❒ No

Please explain _____

REVIEW OF SYSTEMS

Please describe your general health: Excellent Good Fair Poor

Please check Yes or No to the following health questions, past or present:

Head and Neck

Eye disease/injury or sight impairment	☐ Yes	☐ No
Ear disease/injury or hearing impairment	☐ Yes	☐ No
Nose, sinus, mouth, throat complaints	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No

Cardiovascular

Chest pain or angina	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Heart valve problem	☐ Yes	☐ No
Heart palpitations or fluttering	☐ Yes	☐ No
Swelling of ankles, feet or hands	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Weakness or fatigue	☐ Yes	☐ No
High blood pressure (hypertension)	☐ Yes	☐ No
Peripheral vascular disease	☐ Yes	☐ No

Gastrointestinal

Ulcer or other stomach problem	☐ Yes	☐ No
Indigestion or pain after eating	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No
Liver disease, hepatitis or jaundice	☐ Yes	☐ No
Gallbladder disease	☐ Yes	☐ No
Colon or bowel disease	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Rectal bleeding	☐ Yes	☐ No
Persistent change in bowel habits	☐ Yes	☐ No

Genitourinary

Bladder or kidney infections	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Difficulty urinating	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Impotence	☐ Yes	☐ No

Hematopoietic

Blood clots	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Do you take aspirin?	☐ Yes	☐ No
Do you take blood thinners?	☐ Yes	☐ No

Metabolic / Endocrine

Sugar in urine	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Do you take steroids?	☐ Yes	☐ No
Thyroid goiter	☐ Yes	☐ No

Musculoskeletal

Bone fractures	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Type _____		

Neurologic

Fainting spells / Loss of consciousness	☐ Yes	☐ No
Convulsions / Seizures	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Frequent or severe headaches	☐ Yes	☐ No

Psychological

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Sleep disorders	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No

Respiratory

Chronic or frequent cough	☐ Yes	☐ No
History of tuberculosis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Emphysema / COPD	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Skin

Skin cancer	☐ Yes	☐ No
Other skin disease	☐ Yes	☐ No

Signature _____ Date _____