Medical History (Major or Chronic Illness)

Approx. Year of Onset	Diagnosis

Surgical History

Year	Type of Operation

MEDICATIONS – Prescription/OTC/Herbal

Allergies

Drug	Reaction

Immunizations

Type	Year
Tetanus	
Flu (seasonal)	
Pneumovax	
Zoster (Shingles)	

Patient Name

DOB

Date

Social History

Habits:

Tobacco Use (How much, how long?) _____

Alcohol Use (Average Daily Use) _____

Caffeine Products (Average Daily Use) _____

Drug History (Which drugs, how long?) _____

		Yes	No	Comments
Diet:	General Healthy	◯	◯	_____
	Eat Out > 1 x weekly	◯	◯	_____
	Fast Food > 1 x weekly	◯	◯	_____
	I have issues	◯	◯	_____

Exercise (How often, what type?) _____

Hobbies: _____

_____

Marital Status: _____

Age of Children: _____

Lives with: _____

Present Occupation (Include hours per week): _____

Career History (If retired): _____

_____

Year Retired (If Applicable): _____

Education (Highest Year or Degree Obtained): _____

Religious Affiliation: _____

Miscellaneous: _____

_____

_____ _____ _____

Patient Name DOB Date

Family History

	Age (If living)	Age (At time of death)	Cause of Death
Mother			
Father			
Brother/Sister (Circle One)			
Brother/Sister (Circle One)			
Brother/Sister (Circle One)			
Brother/Sister (Circle One)			
Brother/Sister (Circle One)			

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐

Review of Systems

Circle symptoms or problems which apply to you. If there are any terms that are not clear, please ask the doctor to explain at the time of your exam. Please place an "X" in the circle provided beside the category if none of the symptoms apply to you.

General Health: **Weight at Age of 18_____, Maximum Weight_____,** Recent Weight Change; Fatigue; Loss of Appetite; Fever; Chills; Night Sweats. ◯ **Describe your health (circle one): Excellent, Fair, Poor, Failing**	
Dermatologic: Skin Cancers; Psoriasis; Seborrhea; Hives; Recurring rashes ◯	
Head, Ears, Eyes, Nose, Throat: Head Injury; Nose Bleeds; Recurrent sinus infections; Seasonal allergies; Glaucoma; Cataracts; Unusual Visual Disturbances; Ringing in Ears; Dizziness; Swallowing Disorders; Hoarseness; Gum Disease. ◯ **Date of Last Eye Exam: _____** **Date of Last Dental Exam: _____**	
Pulmonary: Pneumonia; Asthma; Tuberculosis; Chronic Cough; Coughing up Blood; Positive TB Skin Test or TB Exposure; Shortness of Breath ◯ **Date of Last Chest X-ray: _____**	
Cardiac: History of Rheumatic Fever; Murmur; Chest Pain; Heart Attack; Swelling of Legs; Irregular or Skipped Heart Beats; Inability to Lie Flat (because of shortness of breath). ◯ **Last EKG: _____**	
Vascular: History of Hypertension (High Blood Pressure); Leg Pains When Walking: Clots; Aneurysm. ◯	
Gastrointestinal: Indigestion/Hiatal Hernia; Peptic Ulcer Disease; Hepatitis; Gallbladder Disease; Pancreatitis; Diarrhea; Constipation; Rectal Bleeding; Recurrent Nausea or Vomiting; Food Intolerance; Change in Bowel Habits ◯ **Date of last Colonoscopy: _____**	
Musculoskeletal: Pain; Stiffness or Swelling of the Joints; Fractures; Back Aches; Disc Syndrome. ◯ **Date of Last DEXA Scan: _____**	

Patient Name: _____ Date: _____

Genitourinary: Recurrent Bladder or Kidney infections; Kidney Stones; Prostate Disorder; Incontinence; Frequent Urination; Urination at Night; Blood in Urine. ◯	
Gynecological: Abnormal PAP Smears; Breast Disorder. ◯ **Number of Pregnancies:**_____ **Number of Miscarriages:** _____ **Month/Year Last Menstrual Period:** _____ **Name of Gynecologist:** _____ **Date of Last PAP Smear:** _____ **Date of Last Mammogram:** _____	
Endocrine: Diabetes; Thyroid Disorder; High Cholesterol or Triglyceride ◯	
Hematology: Anemia; Easy Bruising; Bleeding Disorder; History of Transfusions ◯	
Neurology Seizures; Convulsions or Epilepsy; Fainting Spells; Stroke; Ministroke; Recurrent Headaches; Memory Impairments; Numbness or Weakness. ◯	
Psychiatric: Stress; Depression; Anxiety; Mood Swings; Hallucinations; Suicide History ◯	
Sleep: Difficulty Falling Asleep; Difficulty Staying Asleep; Early morning Awakening; Snoring; Day-time Drowsiness; Sleep Apnea ◯	

Patient Name: _____ Date: _____