MEDICAL & FAMILY HISTORY

1. Reason for your visit today____

2. Please indicate if you are having any current problems signs or symptoms in any of the following areas:

√		√	
	General Wellness		Neurological
	Eyes		Allergies
	Skin		Reproductive/Urinary
	Ears, Nose, Throat		Thyroid/Endocrine
	Stomach/Digestion		Psychiatric
	Lungs/Breathing		Blood/Lymph
	Heart/Circulation		Other
	Muscles/Joints/Bones		Other

Physician Comments - Review of Systems

AII other systems negative

ROS: 1 prob. pertinent, 2-9 extended, 10+complete

3. Medication(s) (drugs, pills):

4. Previous Surgeries/Dates:

5. Allergies

6. What is your Social History?

Marital Status: Single , Divorced , Married , Widow/Widower , Who lives with you?__________________________________

Current Occupation/Employer ____________________________________What kind of work?__________________________________

Do you smoke? __________ How many packs a day? _____________ For how many years? _____________________

Do you drink alcohol?____________ How many drinks per day?_____ per week?______ per month?_________

Are you sexually active? ___________Do you use illicit drugs? ___________If yes, what kind?________________________________

7. What is the Health Status of Your Family?

Mother:____

Father:____

Brothers/Sisters:____

Family Illnesses:

History of Heart Disease (heart attack, heart failure) yes no History of strokes? yes no

History of high blood pressure? yes no History of diabetes? yes no History of cancer? yes, site _______________ no