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

   All 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