



NAME \_\_\_\_\_

MRN: \_\_\_\_\_

Appointment Date \_\_\_\_\_

## ★ REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE				OR CHECK	NONE	Describe
M/S	Rheumatoid Arthritis	Gout	Back Pain	<input type="checkbox"/>		
	Osteoporosis	Fracture	Which bone?	<input type="checkbox"/>		
GI	Heartburn	Ulcers	Nausea Vomiting	Blood in stool	<input type="checkbox"/>	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	<input type="checkbox"/>		
CONST	Weight Loss	Frequent Fever	Loss of appetite	<input type="checkbox"/>		
EYE	Blurred Vision	Double Vision	Vision loss	<input type="checkbox"/>		
ENT	Hearing Loss	Hoarseness	Trouble swallowing	<input type="checkbox"/>		
C-VASC	Chest Pain	Palpitations		<input type="checkbox"/>		
RESP	Chronic Cough	Shortness of Breath		<input type="checkbox"/>		
GU	Painful Urination	Blood in Urine	Kidney Problems	<input type="checkbox"/>		
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	<input type="checkbox"/>		
NEURO	Headaches	Dizziness	Seizures	<input type="checkbox"/>		
PSYCH	Drug / Alcohol Problem	Depression	Sleep Disorder	<input type="checkbox"/>		
HEME	Easy bleeding	HIV / AIDS	Hemophilia	<input type="checkbox"/>		

ALLERGY Do you have ALLERGIES to medications?  Y  N If YES, LIST ALLERGIES TO MEDICINE BELOW

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## ★ PAST MEDICAL HISTORY

WHAT MEDICATIONS DO YOU TAKE?  None Please list below with dosage

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you a Diabetic?  Y  N TREATMENT:  Insulin  Oral Meds  Diet  None

HAVE YOU EVER HAD? : Circle any conditions below:  I do not have any of the conditions listed below

Asthma	Sulfa allergy	Heart attack (year)	Stroke
Aspirin sensitivity	Kidney failure	High Blood Pressure	Cancer (location)
Stomach ulcers	Hepatitis	Heart failure	Notes:
Bleeding ulcers	Liver Disease	COPD	
Stomachache taking anti-inflammatories (NSAIDS) Which NSAIDS?			
Blood Clots that you had to take blood thinners to treat? <input type="checkbox"/> Y <input type="checkbox"/> N When?			

## PAST SURGICAL HISTORY:

What operations have you had? When?  None \_\_\_\_\_

Have you ever had a reaction to anesthesia?  Y  N

PAST HOSPITALIZATIONS (Not for surgery)  None \_\_\_\_\_

## ★ FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Hemophilia \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Diabetes \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_  None

Do any direct relatives have the same condition you are being seen for today?  Y  N Relationship \_\_\_\_\_

## ★ SOCIAL HISTORY:

Do you use tobacco?  Y  N Packs per day \_\_\_\_\_ Alcohol use?  None  Social  Daily  Frequently

Marital Status: M S D W How many people live with you? \_\_\_\_\_

Occupation: \_\_\_\_\_  Student Employer: \_\_\_\_\_

Do you like your job  Y  N Do you plan to be working 6 months from now?  Y  N

PLEASE SIGN: The information on these two forms is accurate to the best of my knowledge. \_\_\_\_\_

For Office use only

Complete \_\_\_\_\_ Date / / Review #1 by \_\_\_\_\_ MD Date / / Review #2 by \_\_\_\_\_ MD Date / /