

Social History

Marital Status: M S D W G Years Married: _____ Number of children: _____
 # of marriages: _____
 Occupation: _____ Where Employed: _____

Risk Factors:

Diet: regular low cholesterol low fat low sodium diabetic other
 Exercise type: _____ How often: _____ How long? _____
 Tobacco Use: Yes No Current Amount _____ Quit Date: _____
 Alcohol: amount: _____ How often: _____
 Recreational Drug Use: Yes No Type/Frequency: _____
 Seat belt Use: Yes No _____%

Review of Systems

PLEASE CIRCLE ANY OF THE SYMPTOMS THAT MAY PERTAIN TO YOU

General: fevers, chills, sweats, anorexia, fatigue, malaise, weight loss

Breast: pain, lump, skin changes, nipple discharge, other _____

Eyes: double vision, blurring, irritation, discharge, vision loss, or eye pain

Ears/Nose/ Throat: ear pain or discharge, decreased hearing, nosebleeds, sore throat, hoarseness, difficulty swallowing

Cardiovascular: chest pains, palpitations, blackouts, shortness of breath upon exertion, swelling of the legs or ankles

Respiratory: cough, wheezing, shortness of breath, excessive sputum, blood with sputum

Gastrointestinal: nausea, vomiting diarrhea, constipation, change in bowel habits, abdominal pain, blood in stool, jaundice (yellowing of the eyes, skin)

Genitourinary: difficulty urinating, blood in urine, painful urination, urinating frequently or multiple times during the night, discharge, hesitancy, incontinence or leakage, genital sores, decreased libido

Musculoskeletal: joint pain or swelling, muscle cramps or weakness, back pain,

Skin: rash, itching, or suspicious moles/growths, dryness

Neurologic: paralysis, weakness, numbness in extremities, seizures, passing out, tremors, dizziness

Psychiatric: serious depression, excess anxiety, suicidal ideation, hallucinations, paranoia, memory loss

Endocrine: cold intolerance, heat intolerance, excess thirst, recent weight change

Heme/lymphatic: abnormal bruising or bleeding, enlarged lymph nodes

Allergic/Immunologic: rash, hay fever, persistent infections, HIV exposure

Preferred Pharmacy: _____ Phone #: _____

Location: _____

List all medications, including prescriptions and over the counter, vitamins and/or supplements below:

Medication Name	Dosage	Taken how often	Taken for what condition

List any allergies that you have and what reaction you had:

Allergen	Reaction	Allergen	Reaction

No Known Allergies