



Social History: Married Single Significant Other Divorced

Health Status of significant other: _____

Children: _____

Health Status of Children: _____

Occupation: _____

<p>Consume Alcohol</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p>Drug Use</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p>Tobacco Use</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>	<p>Caffeine Use</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How Often? _____</p> <p>_____</p>
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REVIEW OF SYSTEMS

<p>In General:</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anesthetic reaction</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> None</p> <p>Eyes:</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>Ears, Nose, Throat:</p> <p><input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> Vertigo/Dizziness</p> <p><input type="checkbox"/> Ringing on ears</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>Skin:</p> <p><input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p>Musculoskeletal:</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Amputation</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>Psychiatric:</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>GI:</p> <p><input type="checkbox"/> Hiatal hernia</p> <p><input type="checkbox"/> Ulcers/bleeding from gastrointestinal tract</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Acid reflux</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p>Hematology:</p> <p><input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Blood transfusions</p> <p><input type="checkbox"/> None</p> <p>Renal:</p> <p><input type="checkbox"/> Prostate</p> <p><input type="checkbox"/> Kidney dysfunction</p> <p><input type="checkbox"/> Incontinence/loss of urine</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Urinary tract infections</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>Allergies & Immunology:</p> <p><input type="checkbox"/> Immune disorder</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p>Respiratory:</p> <p><input type="checkbox"/> Sleep apnea/breathing stops while sleeping</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> None</p> <p>Glandular/Endocrine:</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Uric acid</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p> <p>Neurological:</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Parkinson's</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> ALL OTHER SYSTEMS NEGATIVE</p>
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Comments on all check items:



Past Surgeries/Significant Illnesses:

Date:

MD/Hospital:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication (please include over the counter and vitamins)

Dosage per day

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

Allergies/Intolerances

Allergic to X-Ray dye Yes No Unknown

Family History

Illnesses

Deceased

Living

Mother: _____

Father: _____

Brother: _____

Brother: _____

Sister: _____

Sister: _____

Signature _____