

Last Name: _____ First Name: _____ Middle Name: _____ Date: ____/____/____

Social History – Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Never smoked | How much? _____ packs/day for _____ years |
| <input type="checkbox"/> Smokes cigarettes / cigars | How long ago? _____ () days () months () years |
| <input type="checkbox"/> Quit smoking | How much? _____ cups/day () regular () decaf |
| <input type="checkbox"/> Drinks coffee / tea | How much? _____ () caffeine () caffeine-free |
| <input type="checkbox"/> Drinks soft drinks | How much? _____ |
| <input type="checkbox"/> Drinks alcoholic beverages | () No () Yes Type: _____ |
| <input type="checkbox"/> Uses street drugs | |

Medication Allergies

No Medication Allergies

List all medications you are allergic to: _____

Medications

Not Currently Taking Any Medications

List all medications (including over-the-counter) you are currently taking: _____

Review of Systems – Check all that apply

Do you have any of the following symptoms?

- Weight Loss _____ lbs
 Weight Gain _____ lbs

Cardiovascular:

- Chest Pain
 Palpitations
 Other: _____

Constitutional:

- Fever
 Chills
 Other: _____

Ear/Nose/Throat:

- Sore Throat
 Other: _____

Eyes:

- Blurred Vision
 Double Vision
 Loss of Vision
 Other: _____

Gastrointestinal:

- Nausea/Vomiting
 Diarrhea
 Other: _____

Genitourinary:

- Renal Failure
 Dialysis
 Urinary Leakage:
 with coughing, laughing, sneezing
 with activity
 while sleeping
 constantly
 Other: _____

Musculoskeletal:

- Back Pain
 Joint Pain
 Other: _____

Neurological:

- Headaches
 Paralysis
 Numbness
 Other: _____

Psychiatric:

- Depression
 Mental Illness
 Retardation
 Other: _____

Respiratory:

- Shortness of Breath
 Persistent Cough
 Other: _____

For men:

- Difficulty with Erections?
 Yes
 No

For women:

- Do you Practice Birth Control?
 Yes Method? _____
 No

Last menstrual period? _____

Date: _____

Patient Signature: _____