



**FAMILY HISTORY**

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes No Yes No Yes No Other
Alzheimers Diabetes Osteoporosis
Arthritis Gout Stroke
Cancer Heart Disease Sudden Death

**SOCIAL HISTORY**

Do you smoke or chew tobacco? Yes No Number: packs per day for years
Do you drink alcoholic beverages? Yes No Amount and frequency:
Do you use recreational drugs? Yes No Type and frequency:

**REVIEW OF SYSTEMS** Please check the following symptoms you have experienced on a regular basis:

**GENERAL**

- Fever
Weight Change
Hormonal problems
Other
NONE

**CARDIOVASCULAR**

- Chest Pain
Palpitations
Fluid/swelling in extremities
Other
NONE

**KIDNEY/BLADDER**

- Painful urination
Frequent urination
Incontinence
Other
NONE

**EYES**

- Glasses/contacts
Cataracts
Glaucoma
Other
NONE

**RESPIRATORY**

- Shortness of breath
Sleep apnea
Wheezing
Other
NONE

**EARS, NOSE, THROAT**

- Difficulty swallowing
Ear pain
Seasonal allergies
Hard of hearing
Other
NONE

**GASTROINTESTINAL**

- Heartburn
Diarrhea/Constipation
Abdominal pain
Nausea/vomiting
Other
NONE

**SKIN**

- Rashes
Lumps
Other
NONE

**HEMATOLOGIC/LYMPHATIC**

- Anemia
Blood problems
Clotting disorder
Lymph problems
Other
NONE

**NEUROLOGICAL**

- Headaches
Numbness
Tingling
Seizures
Weakness
Other
NONE

**PSYCHOLOGICAL**

- Anxiety
Depression
Mood swings
Other
NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1-10.

No Pain 0 1 2 3 4 5 6 7 8 9 Extreme Pain 10

Patient Name: Date:

Patient Signature: Date:

Reviewed by: Date: