

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?		
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? Y 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 ____/____/____

