

DATE: \_\_\_\_\_

AGE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

SEX: M F

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

REASON FOR VISIT TODAY: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

When did the condition first occur? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last exam by your Primary Care Physician or Internist: \_\_\_\_\_

Allergies (include reaction): \_\_\_\_\_

\_\_\_\_\_

Current Medications (please include aspirin, ibuprofen, birth control pills, etc. and dosage):

\_\_\_\_\_

\_\_\_\_\_

Medical Illnesses: \_\_\_\_\_

\_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

\_\_\_\_\_

**FAMILY & SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

Spouse Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

No. of Children: \_\_\_\_\_

History of Family Illnesses: \_\_\_\_\_

\_\_\_\_\_

Alcohol Use (describe type & amount): \_\_\_\_\_

Never      Occasionally      Daily      Weekly

Tobacco Use (describe type & amount): \_\_\_\_\_

Never      Occasionally      Daily      Weekly

Special Diet (describe type & amount): \_\_\_\_\_

Never      Occasionally      Daily      Weekly

REVIEW OF SYSEMS:

Please indicate any history of problems with the following:

	Yes/No		Yes/No		Yes/No
Weight Loss/Gain	<input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/> <input type="checkbox"/>
Fever/Chills	<input type="checkbox"/> <input type="checkbox"/>	Reflux	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>	Indigestion	<input type="checkbox"/> <input type="checkbox"/>	Seizures	<input type="checkbox"/> <input type="checkbox"/>
Cough	<input type="checkbox"/> <input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/> <input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/> <input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/>	Hernia	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>
Palpitations	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Implants	<input type="checkbox"/> <input type="checkbox"/>
Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Urinary Symptoms	<input type="checkbox"/> <input type="checkbox"/>	Skin or Breast Mass	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Change in Bowel Habit	<input type="checkbox"/> <input type="checkbox"/>	Abnormal Mouth	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Ear, Nose,	<input type="checkbox"/> <input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Ulcer	<input type="checkbox"/> <input type="checkbox"/>	Bleeding	<input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>

If answered yes to any of the above, please describe in detail:

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PHYSICIAN COMMENTS:

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Patient Signature: \_\_\_\_\_

Attending Physician: \_\_\_\_\_