



**IMPORTANT IMPORTANT IMPORTANT PLEASE LIST:**

**ALLERGIES:** \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**REASON FOR TODAY'S VISIT (Chief Complaint)**

Current or past problems with: (Review of System)

	YES	NO	(IF YES, EXPLAIN)
<b>GENERAL HEALTH</b>			
EYES	_____	_____	_____
EARS/NOSE/THROAT/ MOUTH	_____	_____	_____
HEART	_____	_____	_____
LUNGS	_____	_____	_____
STOMACH/BOWEL	_____	_____	_____
KIDNEYS	_____	_____	_____
ARTHRITIS/MUSCLES/ JOINTS	_____	_____	_____
SKIN	_____	_____	_____
NERVOUS SYSTEM/BRAIN	_____	_____	_____
PSYCHOLOGICAL DISORDER	_____	_____	_____
THYROID/DIABETES	_____	_____	_____
BLOOD/BLEEDING DISORDER	_____	_____	_____
ALLERGIC/IMMUNOLOGIC	_____	_____	_____
MALE/FEMALE ORGANS	_____	_____	_____

**PLEASE LIST ALL SURGERIES** \_\_\_\_\_

**FEMALES: ARE YOU PREGNANT?** \_\_\_\_ yes \_\_\_\_ no      **PLANNING TO BECOME PREGNANT?** \_\_\_\_ yes \_\_\_\_ no

**FAMILY HISTORY: (Past family & social history)**

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Hayfever	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Eczema	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Lung Disease	_____	_____	_____
Malignant Melanoma	_____	_____	_____
Psoriasis	_____	_____	_____
Skin Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____

**SOCIAL HISTORY: DO YOU LIVE ALONE?** \_\_\_\_ NO \_\_\_\_ YES;      **DO YOU DRINK ALCOHOL?** \_\_\_\_ NO \_\_\_\_ YES

**DO YOU SMOKE?** \_\_\_\_ NO \_\_\_\_ YES-FREQUENCY \_\_\_\_\_      **HOBBIES/LEISURE** \_\_\_\_\_

**ACTIVITIES** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_

**REVIEWED** \_\_\_\_\_ **(MD SIGNATURE)** \_\_\_\_\_ **DATE** \_\_\_\_\_ **UPDATE** \_\_\_\_\_