



Patient Name _____ Age _____ Date _____

Allergies _____ Current medications _____

Reason for today's visit (chief complaint) _____

Current or past problems (Review of symptoms)

Table with columns: Condition, Yes, No. Rows include General Health, Eyes, Ears/Nose/Throat/Mouth, Heart, Lungs, Stomach/Bowel, Kidneys, Arthritis/Muscles/Joints, Skin, Headaches/Seizures, Psychological disorder, Thyroid/Diabetes, Blood/Bleeding disorder, Allergic/Immunologic, Females: Are you pregnant?, and Planning to become pregnant?

Family History (past family and social history)

Mother [] living [] deceased age _____ Father [] living [] deceased age _____
Number of your children _____ age(s) _____

Check the following that have occurred in your family:

Table with columns: Condition, Mother, Father, Blood Relative. Rows include Allergies, Arthritis, Asthma, Cancer, Diabetes, Eczema, Hayfever, Heart Disease, High blood pressure, Lung Disease, Malignant Melanoma, Psoriasis, Skin Cancer, Tuberculosis.

Social History

Do you live alone? [] yes [] no
Do you smoke? [] yes [] no frequency _____
Do you drink alcohol? [] yes [] no frequency _____
Do you use recreational drugs? [] yes [] no frequency _____
Occupation _____ Hobbies/leisure activities _____

Reviewed _____ Date _____ Update _____
(MD Signature)