DATE _____ REASON FOR VISIT/PROBLEM_____

NAME _____AGE_____BIRTH DATE_____

HISTORY OF PRESENT ILLNESS: Please further define reason for visit:

Body Location_____ Severity: (circle) mild/moderate/severe

Time of Day problem occurs: (circle) morning/noon/evening/unknown/no pattern

Duration: problem lasts for _____hours/minutes Frequency: problem occurs_____times per day

Associated symptoms and events_____

MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS: (use reverse if necessary or attach list)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PAST MEDICAL PROBLEMS/SURGERIES: (use reverse if necessary or attach list)

Problem/Surgery Start date/surgery date (approx)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: (medical/neurology problems of father, mother, grandmother/father, sister, brother)

(Please circle all that apply)

FATHER: Alive Deceased Diabetes Heart Disease Hypertension Stroke Mental illness Cancer

Other _____

MOTHER: Alive Deceased Diabetes Heart Disease Hypertension Stroke Mental illness Cancer

Other _____

SIBLINGS: Alive Deceased Diabetes Heart Disease Hypertension Stroke Mental illness Cancer

Other _____

CHILDREN: Diabetes Heart Disease Hypertension Stroke Mental illness Cancer

Other _____

OTHER PERTINENT FAMILY HISTORY (please include if alive or deceased):

_____

NUMBER OF SIBLINGS: Brothers: _____ Sisters: _____

NUMBER OF CHILDREN: Sons: _____ Daughters: _____

SOCIAL HISTORY:

Current height_____ Current weight_____

Currently smoking? Y/N __#packs/day Current alcohol use: none/social/frequent/daily

Education: (circle all that apply) elementary/high school/2 years college/4 years college/some college

History of smoking? Y/N History of alcohol use: none/social/frequent/daily

Residing with: spouse/child-grandchild/significant other/relative/friend/other: _____

Type of work: chemical/office/industrial/computer/none/other:_____

DO YOU HAVE A LIVING WILL/ADVANCE DIRECTIVE? YES NO

REVIEW OF SYSTEMS:

If you have experienced any of the items below, please circle

CONSTITUTIONAL			
Weight Change	Fevers	Fatigue	Anorexia
Night Sweats			
HEENT			
Headache	Double Vision	Blurred Vision	Loss of Vision
Eye Pain	Hearing Loss		
RESPIRATORY			
Cough	Wheeze	Shortness of Breath	Chest Pain w/ Breathing
CARDIAC	Chest Pain	Palpitations	Fainting
GASTROINTESTINAL/GENITOURINARY			
Nausea	Vomiting	Diarrhea	Abdominal Pain
Constipation	Pain with Urination	Heartburn	
HEMATOLOGIC	Abnormal Bleeding	Bruising	Anemia
ENDOCRINOLOGIC	Heat/Cold Intolerance	Excessive thirst/urination	
MUSCULOSKELETAL			
Weakness	Joint Pain	Muscle Pain	Arthritis
ALLERGY	Seasonal Allergies	Excessive Sneezing	Food Allergies
PSYCHIATRY	Depression	Anxiety	Mood Changes
DERMATOLOGIC	Rashes	Itching	
NEUROLOGICAL			
Headaches	Dizziness	Weakness	Numbness
Unsteadiness			