

Patient Name _____ Date of Birth _____ Date _____

SOCIAL HISTORY CHECK (✓) ALL BOXES AND COMPLETE ALL APPLICABLE QUESTIONS REGARDING YOUR SOCIAL HISTORY

Tobacco Use: Current Previous Never
If previous smoker: Year quit _____ Packs per year _____
If current smoker: Year started _____
 Cigarettes - Packs/day _____ Cigars - # per week _____
 Smokeless/Chewing - Amt per day _____
Counseled to quit/cut down: Yes No
Passive smoke exposure: Yes No
Alcohol use: Yes No
Average drink (s) per day: _____
Type: _____
Drink daily: Yes No
Counseled: Yes No
Drug use: Yes No Type: _____
Comments: _____

Caffeine use (#drinks/daily): _____
HIV/AIDS high risk: Yes No
Exercise (#times/week): _____
Seatbelt use: Frequently Occasionally Rarely
Sun Exposure: Frequently Occasionally Rarely
Living arrangements: Single and lives alone
 Single and lives with someone
 Married and lives with spouse
 Married and lives with family
 Divorced and lives alone
 Divorced and lives with someone
 Widowed and lives alone
 Widowed and lives with someone
 Other

PAST MEDICAL HISTORY CHECK (✓) CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

<input type="checkbox"/> AIDS	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Pulmonary Fibrosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> DVT/Phlebitis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary Nodule
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Interstitial Lung Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina/Chest pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Disease-if so, are you on dialysis? _____	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lupus (SLE)	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Sleep Apnea-if so, do you use a CPAP? _____
<input type="checkbox"/> Bone Disease	<input type="checkbox"/> Faint/Dizziness	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Soft Tissue Lesions
<input type="checkbox"/> Breast Cysts	<input type="checkbox"/> GERD	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stent
<input type="checkbox"/> Breast Mass	<input type="checkbox"/> GI Bleed	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter	<input type="checkbox"/> Numbness/Weakness	<input type="checkbox"/> TIA
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Gout	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Transfusions
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Pleural Effusion	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Polio	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Chronic Renal Failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Vaginal Infection
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pulmonary Emboli	
<input type="checkbox"/> COPD-if so, do you use oxygen? _____ L/NC _____	<input type="checkbox"/> High Cholesterol		

PAST SURGICAL HISTORY CHECK (✓) ALL SURGERIES YOU HAVE HAD IN THE PAST

<input type="checkbox"/> Amputation	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Knee Arthroscopy	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> AV Fistula	<input type="checkbox"/> Colostomy/Ileostomy	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> TAH
<input type="checkbox"/> AV Graft	<input type="checkbox"/> D&C	<input type="checkbox"/> Laparoscopy	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Laparotomy	<input type="checkbox"/> Transplant - type _____
<input type="checkbox"/> Axillary Dissection	<input type="checkbox"/> Esophagectomy	<input type="checkbox"/> Liver Transplant	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Bone Fracture - explain _____	<input type="checkbox"/> Gastrectomy	<input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Tunneled Dialysis Catheter
<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Lung Resection	<input type="checkbox"/> Heart Stent
<input type="checkbox"/> Bronchoscopy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Urinary Incontinence Surgery
<input type="checkbox"/> CABG	<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Neck/Back Surgery	<input type="checkbox"/> Other Surgery: _____
<input type="checkbox"/> Carotid Endarterectomy	<input type="checkbox"/> Hepatectomy	<input type="checkbox"/> Nephrectomy	
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Hernia Repair-type _____	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Cataract Extraction	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Pancreatectomy	
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> Pyloroplasty	<input type="checkbox"/> Anesthesia problems-no
		<input type="checkbox"/> Reduction Mammoplasty	<input type="checkbox"/> Anesthesia problems-yes

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REVIEW OF SYSTEMS			
CHECK (✓) YES OR NO TO SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR			
CONSTITUTION	CARDIOVASCULAR	GASTROINTESTINAL	MUSCULOSKELETAL
Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> <input type="checkbox"/> Indigestion	<input type="checkbox"/> <input type="checkbox"/> Muscle cramps
<input type="checkbox"/> <input type="checkbox"/> Chills	<input type="checkbox"/> <input type="checkbox"/> Near Fainting	<input type="checkbox"/> <input type="checkbox"/> Vomiting blood	<input type="checkbox"/> <input type="checkbox"/> Joint pain
<input type="checkbox"/> <input type="checkbox"/> Sweats	<input type="checkbox"/> <input type="checkbox"/> Chest pain/discomfort	<input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> Joint swelling
<input type="checkbox"/> <input type="checkbox"/> Anorexia	<input type="checkbox"/> <input type="checkbox"/> Racing/skipping heart beat	<input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> Back pain
<input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> Yellowish skin color	<input type="checkbox"/> <input type="checkbox"/> Stiffness
<input type="checkbox"/> <input type="checkbox"/> Weakness	<input type="checkbox"/> <input type="checkbox"/> Lightheadedness	<input type="checkbox"/> <input type="checkbox"/> Gas	<input type="checkbox"/> <input type="checkbox"/> Muscle weakness
<input type="checkbox"/> <input type="checkbox"/> Malaise	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath with exertion	<input type="checkbox"/> <input type="checkbox"/> Abdominal pain	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Weight loss	<input type="checkbox"/> <input type="checkbox"/> Palpitations	<input type="checkbox"/> <input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> <input type="checkbox"/> Gout
EAR, NOSE, THROAT	<input type="checkbox"/> <input type="checkbox"/> Swelling of hands or feet	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Loss of strength
<input type="checkbox"/> <input type="checkbox"/> Ringing in ears	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Muscle aches
<input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> Leg cramps	<input type="checkbox"/> <input type="checkbox"/> Change in bowel habits	NEUROLOGIC
<input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> Weight gain	<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Difficulty with concentration
<input type="checkbox"/> <input type="checkbox"/> Decreased hearing	HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/> <input type="checkbox"/> Dark tarry stools	<input type="checkbox"/> <input type="checkbox"/> Poor balance
<input type="checkbox"/> <input type="checkbox"/> Nasal congestion	<input type="checkbox"/> <input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> <input type="checkbox"/> Bloody stools	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Nosebleeds	<input type="checkbox"/> <input type="checkbox"/> Bleeding	GENITO-URINARY	<input type="checkbox"/> <input type="checkbox"/> Disturbances in coordination
<input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> <input type="checkbox"/> Skin discoloration	<input type="checkbox"/> <input type="checkbox"/> Painful urination	<input type="checkbox"/> <input type="checkbox"/> Numbness
<input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> Abnormal bruising	<input type="checkbox"/> <input type="checkbox"/> Blood in urine	<input type="checkbox"/> <input type="checkbox"/> Inability to speak
<input type="checkbox"/> <input type="checkbox"/> Sore throat	<input type="checkbox"/> <input type="checkbox"/> Fevers	<input type="checkbox"/> <input type="checkbox"/> Urinary frequency	<input type="checkbox"/> <input type="checkbox"/> Falling down
<input type="checkbox"/> <input type="checkbox"/> Bleeding gums	SKIN	<input type="checkbox"/> <input type="checkbox"/> Urinary hesitancy	<input type="checkbox"/> <input type="checkbox"/> Seizures
EYES	<input type="checkbox"/> <input type="checkbox"/> Excessive perspiration	<input type="checkbox"/> <input type="checkbox"/> Incontinence	<input type="checkbox"/> <input type="checkbox"/> Tingling
<input type="checkbox"/> <input type="checkbox"/> Vision loss-1 eye	<input type="checkbox"/> <input type="checkbox"/> Night sweats	<input type="checkbox"/> <input type="checkbox"/> Genital sores	<input type="checkbox"/> <input type="checkbox"/> Tremors
<input type="checkbox"/> <input type="checkbox"/> Double vision	<input type="checkbox"/> <input type="checkbox"/> Suspicious lesions	<input type="checkbox"/> <input type="checkbox"/> Decreased libido	<input type="checkbox"/> <input type="checkbox"/> Fainting
<input type="checkbox"/> <input type="checkbox"/> Eye irritation	<input type="checkbox"/> <input type="checkbox"/> Changes in nail beds	MEN only	<input type="checkbox"/> <input type="checkbox"/> Excessive daytime sleeping
<input type="checkbox"/> <input type="checkbox"/> Vision loss-both eyes	<input type="checkbox"/> <input type="checkbox"/> Dryness	<input type="checkbox"/> <input type="checkbox"/> Erection dysfunction	<input type="checkbox"/> <input type="checkbox"/> Memory Loss
<input type="checkbox"/> <input type="checkbox"/> Blurring	<input type="checkbox"/> <input type="checkbox"/> Poor wound healing	<input type="checkbox"/> <input type="checkbox"/> Lump in testicles	PSYCHOLOGIC
<input type="checkbox"/> <input type="checkbox"/> Eye pain	<input type="checkbox"/> <input type="checkbox"/> Skin cancer	<input type="checkbox"/> <input type="checkbox"/> Penis discharge	<input type="checkbox"/> <input type="checkbox"/> Anxiety/nervousness
<input type="checkbox"/> <input type="checkbox"/> Halos	<input type="checkbox"/> <input type="checkbox"/> Itching	<input type="checkbox"/> <input type="checkbox"/> Breast lump	<input type="checkbox"/> <input type="checkbox"/> Thoughts of suicide
<input type="checkbox"/> <input type="checkbox"/> Discharge	<input type="checkbox"/> <input type="checkbox"/> Flushing	WOMEN only	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Light sensitivity	<input type="checkbox"/> <input type="checkbox"/> Rash	<input type="checkbox"/> <input type="checkbox"/> Abnormal pap smear	<input type="checkbox"/> <input type="checkbox"/> Thoughts of violence
RESPIRATORY	ALLERGY/IMMUNOLOGIC	<input type="checkbox"/> <input type="checkbox"/> Abnormal mammogram	<input type="checkbox"/> <input type="checkbox"/> Mental disorder
<input type="checkbox"/> <input type="checkbox"/> Cough	<input type="checkbox"/> <input type="checkbox"/> Persistent infections	<input type="checkbox"/> <input type="checkbox"/> Extreme menstrual pain	<input type="checkbox"/> <input type="checkbox"/> Mood swings
<input type="checkbox"/> <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> <input type="checkbox"/> Hives	<input type="checkbox"/> <input type="checkbox"/> Bleeding between periods	ENDOCRINE
<input type="checkbox"/> <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> <input type="checkbox"/> Rash	<input type="checkbox"/> <input type="checkbox"/> Breast lump	<input type="checkbox"/> <input type="checkbox"/> Excessive hunger
<input type="checkbox"/> <input type="checkbox"/> Chest discomfort	<input type="checkbox"/> <input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> <input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> <input type="checkbox"/> Cold intolerance
<input type="checkbox"/> <input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> <input type="checkbox"/> HIV exposure	<input type="checkbox"/> <input type="checkbox"/> Hot flashes	<input type="checkbox"/> <input type="checkbox"/> Heat intolerance
<input type="checkbox"/> <input type="checkbox"/> Wheezing	GASTROINTESTINAL	<input type="checkbox"/> <input type="checkbox"/> Nipple discharge	<input type="checkbox"/> <input type="checkbox"/> Excessive urination
<input type="checkbox"/> <input type="checkbox"/> Excessive sputum	<input type="checkbox"/> <input type="checkbox"/> Excessive appetite	Last menstrual period _____	<input type="checkbox"/> <input type="checkbox"/> Excessive thirst
<input type="checkbox"/> <input type="checkbox"/> Excessive snoring	<input type="checkbox"/> <input type="checkbox"/> Loss of appetite	Last Pap smear _____	<input type="checkbox"/> <input type="checkbox"/> Weight change
		Last Mammogram _____	
		Do you use birth control? _____	

All information is strictly confidential

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____

Reviewed By (Initial and Date) _____

Reviewed By (Initial and Date) Changes No Changes

Reviewed By (Initial and Date) Changes No Changes

Reviewed By (Initial and Date) Changes No Changes

Reviewed By (Initial and Date) Changes No Changes