NAME | MRN: | Appointment Date

★ REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE			OR CHECK	NONE	Describe
M/S	Rheumatoid Arthritis	Gout	Back Pain	☐	
	Osteoporosis	Fracture Which bone?			
GI	Heartburn Ulcers	Nausea Vomiting	Blood in stool	☐	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	☐	
CONST	Weight Loss	Frequent Fever	Loss of appetite	☐	
EYE	Blurred Vision	Double Vision	Vision loss	☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	☐	
C-VASC	Chest Pain	Palpitations		☐	
RESP	Chronic Cough	Shortness of Breath		☐	
GU	Painful Urination	Blood in Urine	Kidney Problems	☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	☐	
NEURO	Headaches	Dizziness	Seizures	☐	
PSYCH	Drug / Alcohol Problem	Depression	Sleep Disorder	☐	
HEME	Easy bleeding	HIV / AIDS	Hemophelia	☐	

ALLERGY Do you have **ALLERGIES** to medications? ☐Y ☐N If **YES, LIST ALLERGIES TO MEDICINE BELOW**

★ **PAST MEDICAL HISTORY**

WHAT **MEDICATIONS** DO YOU TAKE? ☐None Please list below with dosage

Are you a Diabetic? ☐Y ☐N **TREATMENT:** ☐**Insulin** ☐**Oral Meds** ☐**Diet** ☐**None**

HAVE YOU EVER HAD? : Circle any conditions below: ☐ **I do not have any of the conditions listed below**

Asthma	Sulfa allergy	Heart attack (year)	Stroke
Aspirin sensitivity	Kidney failure	High Blood Pressure	Cancer (location)
Stomach ulcers	Hepatitis	Heart failure	**Notes:**
Bleeding ulcers	Liver Disease	COPD	

Stomachache taking anti-inflamatories (NSAIDS) Which NSAIDS?

Blood Clots that you had to take blood thinners to treat? ☐ Y ☐ N When?

PAST SURGICAL HISTORY:

What operations have you had? When? ☐**None** ______________________

Have you ever had a reaction to anesthesia ? ☐ Y ☐ N

PAST HOSPITALIZATIONS (Not for surgery) ☐**None** ______________________

★ **FAMILY HISTORY:** **Have any direct relatives had any of the following disorders? If so, which relative?**

☐ Hemophilia ______ ☐High Blood Pressure _____ ☐ Diabetes ________ ☐Rheumatoid Arthritis ________ ☐**None**

Do any direct relatives have the same condition you are being seen for today? ☐Y ☐N Relationship

★ **SOCIAL HISTORY:**

Do you use tobacco? ☐Y ☐N **Packs per day** ___ Alcohol use? ☐ None ☐ Social ☐Daily ☐ Frequently

Marital Status: M S D W How many people live with you? ________

Occupation: ____________________ ☐Student Employer: ______________________________

Do you like your job ☐ Y ☐ N Do you plan to be working 6 months from now? ☐ Y ☐ N

PLEASE SIGN: **The information on these two forms is accurate to the best of my knowledge.**______________________________

For Office use only

Complete _______ Date___/___/___ Review #1 by ____________ MD Date ___/___/___ Review #2 by ____________MD Date ___/___/___