Name: _____ DOB:_____

What is the reason for your visit today? _____

MEDICAL HISTORY/FAMILY HISTORY

**** Please circle the family member(s) in which the condition applies****

Diabetes	Self/Mother/Father/Bro/Sis	**Bleeding Problems**	Self/Mother/Father/Bro/Sis
Heart Disease	Self/Mother/Father/Bro/Sis	**Anesthesia Problems**	Self/Mother/Father/Bro/Sis
High blood pressure	Self/Mother/Father/Bro/Sis	**Kidney Disease**	Self/Mother/Father/Bro/Sis
Lung/Asthma	Self/Mother/Father/Bro/Sis	**Stroke**	Self/Mother/Father/Bro/Sis
Hearing Loss	Self/Mother/Father/Bro/Sis	**Thyroid**	Self/Mother/Father/Bro/Sis
Cancer	Self/Mother/Father/Bro/Sis	**Dementia/Alzheimer's**	Self/Mother/Father/Bro/Sis
***AIDS/HIV**	**SELF-YES/NO**	***HEPATITIS C**	**SELF-YES/NO**

List past surgeries/hospitalizations:

☐ No Past Surgeries/hospitalizations

_____

_____

_____

_____

_____

_____

Social History:

Do you smoke? ☐ **YES** ☐ **NO**

Former Smoker? ☐ **YES** ☐ **NO** **Quit Date**_____

NEVER a Smoker ☐

Do you drink alcohol? ☐ **YES, number of drinks per week**_____

☐ **NO**

Occupation _____

MEDICATIONS (PLEASE INCLUDE DOSAGE)

☐ **NOT CURRENTLY TAKING MEDICATIONS** _____

_____

_____

_____

_____

MEDICATION ALLERGIES

LATEX ALLERGY? ☐ Yes ☐ No

☐ **NO KNOWN DRUG ALLERGIES** _____

_____

REVIEW OF SYSTEMS

ARE YOU ***CURRENTLY*** HAVING ANY OF THE FOLLOWING PROBLEMS? *(PLEASE CHECK)*

GENERAL
- ☐ Fever greater than 99°
- ☐ Unexplained weight loss
- ☐ Fatigue/Weakness

EYES
- ☐ Dry or itchy eyes
- ☐ Decreased vision

EARS
- ☐ Ringing or noise in the ears
- ☐ Ear Pain or drainage
- ☐ Hearing Loss

NOSE
- ☐ Blocked or runny nose
- ☐ Loss of smell
- ☐ Nose bleeds

THROAT
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Hoarse/Rough voice
- ☐ Frequent throat-clearing

LUNGS
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma

STOMACH
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea or vomiting
- ☐ Bloody stools

BONES AND MUSCLE
- ☐ Arthritis
- ☐ Muscle Pain

SKIN
- ☐ Changes in mole or wart
- ☐ New skin growth

HEART
- ☐ Chest pain with activity
- ☐ Irregular heart beat

NEURO
- ☐ Change in facial muscle strength
- ☐ Loss of facial sensation
- ☐ Headaches

ALLERGY/IMMUNO
- ☐ Seasonal allergies