Name: (Last, First, Middle) ______________________ **Account #** __________

Illnesses - Please list all major illnesses

Surgeries - Please list any surgical procedures

Procedure	Year	Prodcedure	Year

Medications - Please list **ALL CURRENT** medicines

Medications	How Much / How Often	Medications	How Much / How Often
Aspirin			

Allergies - Please list all MEDICATION allergies

Social History

smoking	N Y	I smoke(d) ______ packs/day for ______ years **OR** I quit for ____ years
alcohol	N Y	I have ______ drinks/day **OR** I drink socially (less than 3 drinks/week)

Family Medical History

Father:
Mother:
Other:

Review of Systems Do you **CURRENTLY** have any problems related to the following systems? Circle Y(es) or N(o).

General
- Fever Y N
- Chills Y N
- Headache Y N
- Other Y N

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other Y N

Ear/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Sinus Problem Y N
- Other Y N

Respiratory Y N
- Wheezing Y N
- Cough Y N
- Short of Breath Y N
- Other

Musculoskeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other Y N

Cardiovascular
- Chest Pain Y N
- Palpitations Y N
- Hypertension Y N
- Other Y N

Gastrointestinal
- Stomach Pain Y N
- Nausea Y N
- Vomiting Y N
- Indigestion Y N
- Other Y N

Endocrine
- Too Thirsty Y N
- Too Hot/Cold Y N
- Tiredness Y N
- Other Y N

Skin
- Skin Rash Y N
- Persistent Itch Y N
- Other Y N

Urological
- Urinate often Y N
- Painful Urinaltion Y N
- Urinate Slowly Y N
- Urinate at Night Y N
- Urinary Leakage Y N
- Incomplete Emptying Y N
- Other Y N

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness Y N
- Tingling Y N
- Other Y N

Hematologic/Lymphatic
- Swollen Gland Y N
- Bleeding Prob. Y N
- Other Y N

Allergy/Immunology
- Hay Fever Y N
- Drug Allergy Y N
- Other Y N

Psychological
- Depression Y N
- Other Y N

Physician use only: (Notes/Comments)

#Systems	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician Signature ______________________ Date ________