

SOCIAL HISTORY: (please answer the following)

Do you/have you ever smoked? YES NO

How much alcohol do you drink? _____

Marital status: Married Divorced Single Widow(er) _____

HIV exposure: YES NO _____

Occupation: _____ Hobbies: _____

Diet restrictions: _____

Recreational Drugs: YES NO
(Examples: Cocaine, Marijuana, Anabolic steroids, etc.)**SURGERIES: (please list all prior surgeries an the year performed)**

REVIEW OF SYSTEMS: (please check all that apply)

HEAD	GASTROINTESTINAL	BLOOD
_____ HEADACHES	_____ ABDOMINAL PAIN	_____ ANEMIA
_____ INJURY	_____ ACID REFLUX	_____ BLEED EASILY
	_____ CONSTIPATION	_____ BLOOD CLOTS
	_____ DIARRHEA	_____ TRANSFUSION
EYES	_____ DIVERTICULOSIS	
_____ BLEEDING	_____ GALL BLADER PROBLEMS	CONSTITUTIONAL
_____ CATARACTS	_____ HEARTBURN	_____ CHILLS
_____ GLAUCOMA	_____ HEPATITIS/JAUNDICE	_____ FEVER
_____ LASER SURGERY	_____ HIATAL HERNIA	_____ SLEEP PROBLEM
_____ RETINOPATHY	_____ NAUSEA/VOMIT	_____ WEIGHT CHANGE
	_____ PANCREATITIS	
EAR/NOSE/THROAT	_____ ULCERS	MUSCULOSKELETAL
_____ DENTURES		_____ ARTHRITIS
_____ HEARING LOSS	ENDOCRINE	_____ BACK PAIN
_____ HOARSENESS	_____ ADRENAL	_____ GOUT
_____ NOSEBLEEDS	_____ PARATHYROID	_____ RASHES
_____ SINUS PROBLEMS	_____ PITUITARY	_____ SWELLING
_____ SORES IN MOUTH	_____ THYROID	
_____ STREP THROAT		MENTAL HEALTH
	NEUROLOGIC	_____ ANXIETY
RESPIRATORY	_____ DIZZY SPELLS	_____ DEPRESSION
_____ ASTHMA	_____ PARALYSIS	_____ SCHIZOPHRENIA
_____ CHRONIC COUGH	_____ SEIZURES	
_____ COUGH UP BLOOD	_____ STROKE	CANCER YES NO
_____ EMPHYSEMA	_____ WEAKNESS	TYPE OF CANCER _____
_____ PNEUMONIA		WHEN? _____
_____ TROUBLE BREATHING	DIABETES YES NO	TREATMENT? _____
_____ TUBERCULOSIS	HOW LONG? _____	
	_____ EYE PROBLEMS	
HEART	_____ NEUROPATHY	
_____ CHEST PAIN	HYPERTENSION YES NO	
_____ HEART ATTACK	HOW LONG? _____	
_____ HEART FAILURE	HOME CUFF? _____	
_____ HEART MURMUR		
_____ PACEMAKER		
_____ PALPITATIONS		
_____ RHEUMATIC FEVER		
_____ VALVE REPLACEMENT		