Last Name: _____ **First Name**: _____ **Date:** _____

PAST MEDICAL HISTORY	YES	NO
Heart Disease		
Hypertension		
Diabetes		
Seizures or Stroke		
Tumors or Cancer		
Lung Disease		
Liver Disease		
Ulcers		
Kidney Disease		
Tuberculosis		
Phlebitis or Blood Clots		
Thyroid Disease		

PAST SURGICAL HISTORY - OPERATIONS	DATE

SOCIAL HISTORY	
1) TOBACCO	Yes_____ No_____
How many packs per day? _____	How many years? _____
Have you stopped? _____	
2) ALCOHOL	Yes_____ No_____
How many drinks per day? _____	How many years? _____

3) ALLERGIES TO MEDICATIONS:

ADDITIONAL COMMENTS:

REVIEW OF SYSTEM:		YES	NO
ARE YOU EXPERIENCING ANY PROBLEMS REGARDING:			
1) NEURO	Dizziness		
	Light-headedness		
	Fainting		
	Weakness of Arms or Legs		
2) CARDIAC	Chest Pain		
	Chest Pressure		
	Chest Tightness		
	Chest Squeezing		
	Palpitations		
	Angina		
3) RESPIRATORY	Shortness of Breath		
	Coughing		
	Chest Pain		
	Fevers		
	Shrotness of Breath While Lying Flat		
	Awakening with Shortness of Breath		
4) GI	Nausea		
	Vomiting		
	Vomiting Blood		
	Diarrhea		
	Abdominal Pain		
	Weight Loss		
5) GU	Burning While Urinating		
	Frequent Urination		
	Inability to Urinate		
	Urinating at Night		
6) MS	Swelling of Legs		
	Swelling of the Joints		
	Inflammation of the Joints		
	Pain While Walking		