Name (Print)_____ Date_____

Signature _____

Social History ***Please circle/check all items that apply***

Alcohol	Yes/ No		Illegal Drug Use	Yes/ No		Smoking	Yes/ No
Any DWI	Yes/ No		Marijuana, cocaine, etc.			Packs per day	_____
Single	Yes/ No		Separated	Yes/ No		Married	Yes/ No
Divorced	Yes/ No		Widowed	Yes/ No		# of Children	_____
Working full time	Yes/ No		Working Part time	Yes/ No		Retired	Yes/ No
Loss of Job	Yes/ No		Job problem	Yes/ No			

Occupation (describe) _____

Family History

Thyroid	Yes/ No		Pneumonia	Yes/ No		Asthma	Yes/ No
Heart Attack	Yes/ No		Angina	Yes/ No		Jaundice	Yes/ No
Ulcer	Yes/ No		Diabetes	Yes/ No		Stroke	Yes/ No
(peptic/gastric)			Gout	Yes/ No		Early Death	Yes/ No
Hepatitis	Yes/ No		Mental Illness	Yes/ No		Cancer	Yes/ No
High blood pressure	Yes/ No						

Other _____

Surgical History

Thyroid Surgery	Yes/ No		Heart Surgery	Yes/ No		Cataract Surgery	Yes/ No
Sinus Surgery	Yes/ No		Joint Replacement	Yes/ No		Tonsil Surgery	Yes/ No
Gall Bladder	Yes/ No		Breast Surgery	Yes/ No		Uterus Surgery	Yes/ No
Surgery			Bladder Suspension	Yes/ No		Hernia Surgery	Yes/ No
Appendectomy	Yes/ No		Neck Surgery	Yes/ No			
Back Surgery	Yes/ No						

Other Surgeries _____

Medical History

Jaundice	Yes/ No		Hepatitis	Yes/ No		Varicose Vein	Yes/ No
Gout	Yes/ No		Osteoporosis	Yes/ No		Fracture	Yes/ No
Stroke	Yes/ No		Thyroid	Yes/ No		Pneumonia	Yes/ No
Asthma	Yes/ No		Heart Attack	Yes/ No		Angina	Yes/ No
Diabetes	Yes/ No		Ulcer	Yes/ No		Kidney Stone	Yes/ No
Urination Problem	Yes/ No		Prostate	Yes/ No		Cancer	Yes/ No
High blood pressure	Yes/ No		Psoriasis	Yes/ No		Mental Illness	Yes/ No

Other _____

Allergies

Medications	Yes/ No	
Latex	Yes/ No	
Food	Yes/ No	
Dyes/ Iodine	Yes/ No	

Other	Yes/ No	

Name_____

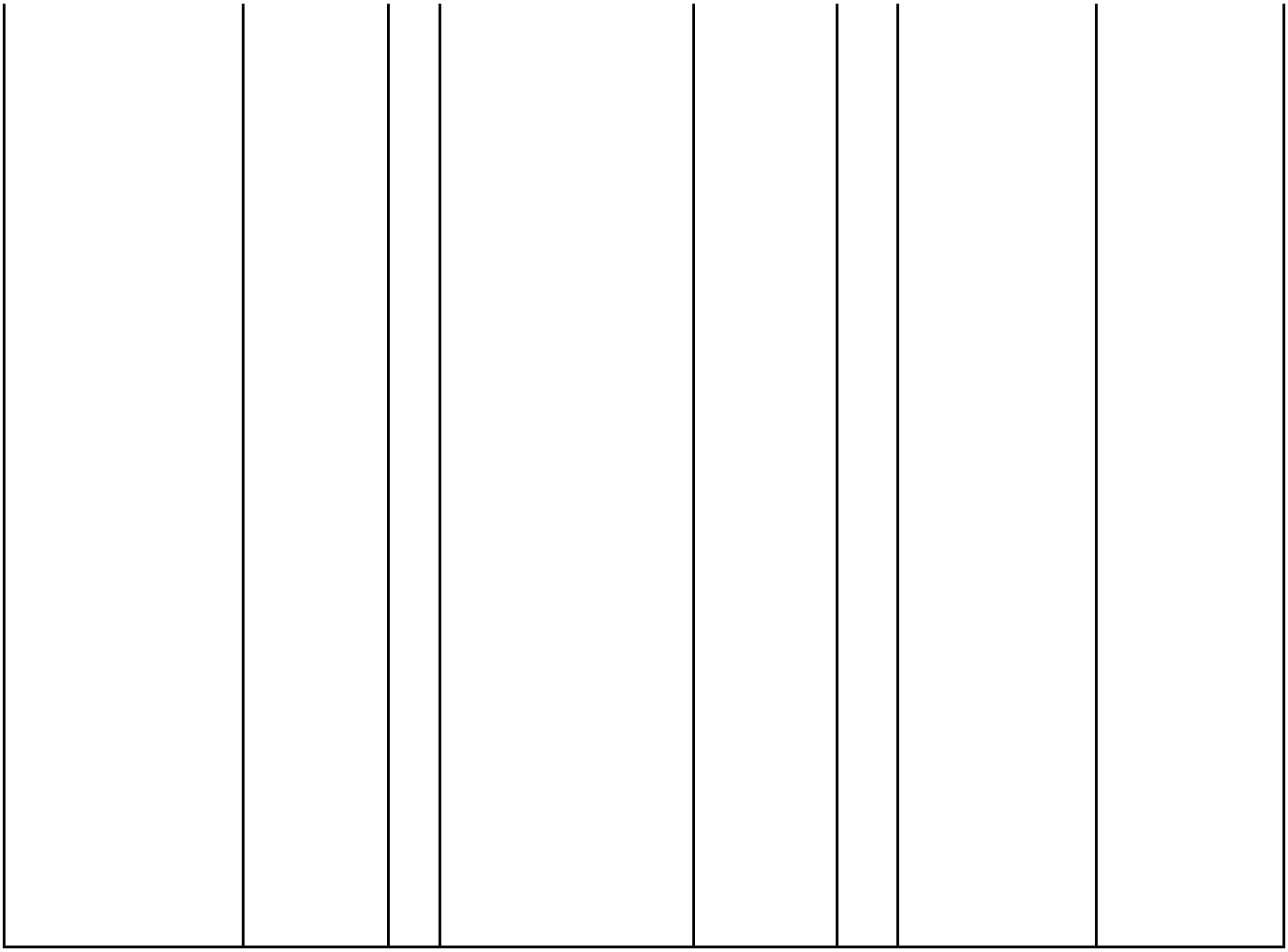
Current Medications

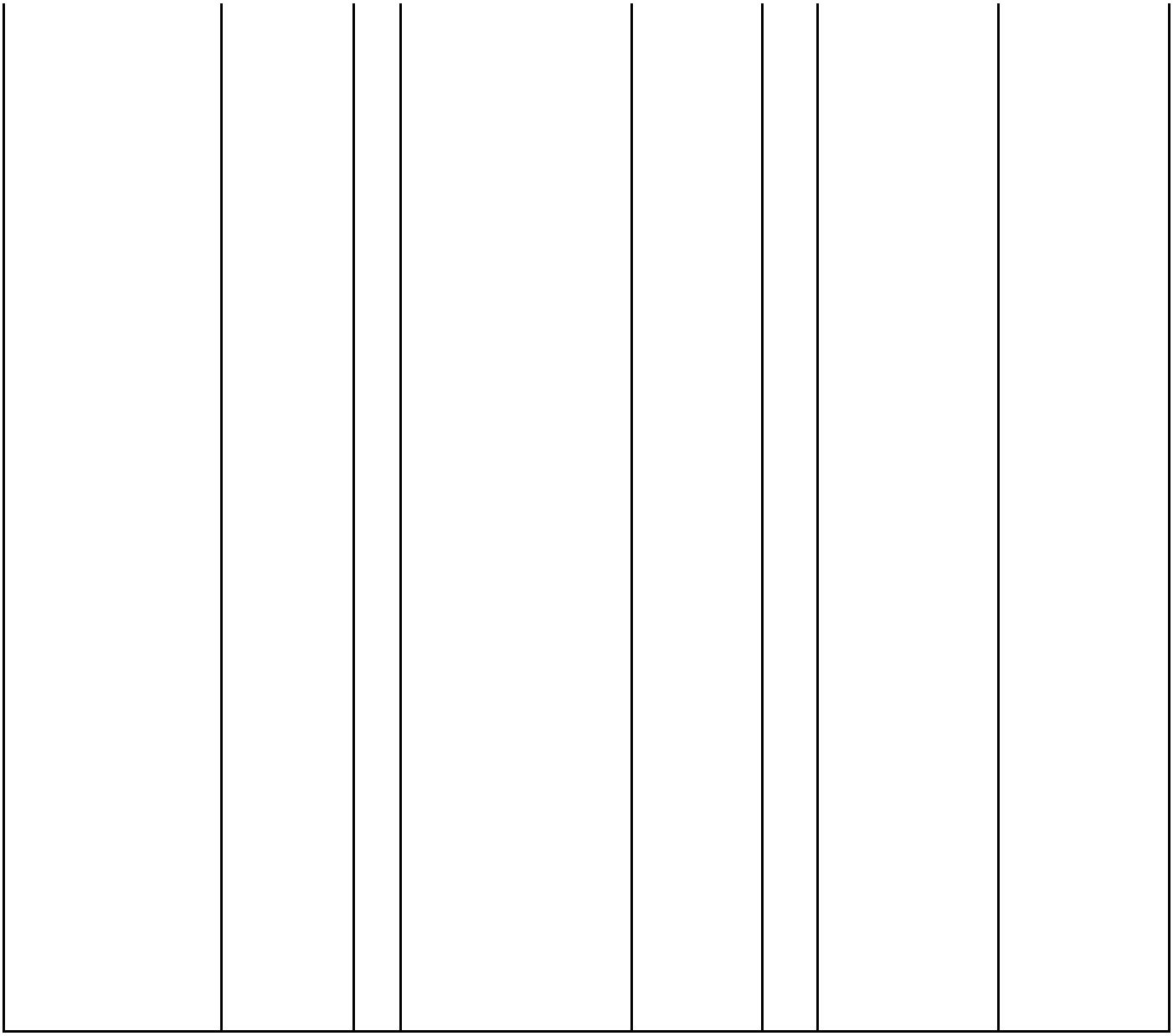
Medicine	Dosage	How Often	Prescribing Physician

If more room is needed please attach list.

Present Symptoms

Systemic							
Weight Change	Yes/ No		Chills	Yes/ No		Fever	Yes/ No
Night Sweats	Yes/ No		Feeling tired	Yes/ No			
Other							
Head							
Headache	Yes/ No		Facial Pain	Yes/ No		Sinus Pain	Yes/ No
Other							
Eye							
Eyesight Problem	Yes/ No		Eye Pain	Yes/ No		Itching Eye	Yes/ No
Other							
ENT							
Earache	Yes/ No		Hearing Loss	Yes/ No		Ringing Ear	Yes/ No
Nose Bleeds	Yes/ No		Mouth Sores	Yes/ No		Bleeding Gum	Yes/ No
Sore Throats	Yes/ No						
Other							
Neck							
Neck Pain	Yes/ No		Neck Stiffness	Yes/ No		Swelling Neck	Yes/ No
Other							
Breast							
Breast Pain	Yes/ No		Nipple Discharge	Yes/ No		Breast Lump	Yes/ No
Other							
Cardiac							
Chest Pain	Yes/ No		Fast Heart Rate	Yes/ No		Palpitation	Yes/ No
Other							
Psychological							
Sleep disturbances	Yes/ No		Anxiety	Yes/ No		Depression	Yes/ No
Other							





Pulmonary							
Shortness breath	Yes/ No		Cough	Yes/ No		Wheezing	Yes/ No
Other							
Gastrointestinal							
Appetite Loss	Yes/ No		Swallowing Problem	Yes/ No		Heart Burn	Yes/ No
Nausea	Yes/ No		Vomiting	Yes/ No		Constipation	Yes/ No
Diarrhea	Yes/ No		Abdominal Pain	Yes/ No		Bloody Stools	Yes/ No
Bowel Incontinence	Yes/ No		Other				
Genitourinary							
Frequent Urination	Yes/ No		Urethral Discharge	Yes/ No		Genital Lesion	Yes/ No
Bloody Urine (unusual)	Yes/ No		Bladder Incontinence	Yes/ No		Other	
Skin							
Pruritus	Yes/ No		Skin Lesions	Yes/ No		Rashes	Yes/ No
Other							
Endocrine							
Excessive Sweat	Yes/ No		Excessive Thirst	Yes/ No		Other	
Musculoskeletal							
Muscle Aches	Yes/ No		Describe Location(s)				
Muscle Cramps	Yes/ No		Describe Location(s)				
Muscle Weakness	Yes/ No		Describe Location(s)				
Ankle Swelling	Yes/ No		Describe Location(s)				
Other			Lower Back Pain	Yes/ No		Limb Pain	Yes/ No
Neurological							
Dizziness	Yes/ No		Fainting	Yes/ No		Convulsions	Yes/ No
Tremor	Yes/ No		Numbness Hand	Yes/ No		Memory Loss	Yes/ No
Numbness Feet	Yes/ No		Weakness	Yes/ No			