

PATIENT NAME: \_\_\_\_\_

CHART: \_\_\_\_\_

**FAMILY HISTORY (Mother, Father, Sister, Brother, Grandparents, Children)**

Condition	Relationship	Type/where	Status
Cancer			
Cancer			
Diabetes			
Diabetes			
Heart Disease			
High cholesterol			
Hypertension			
Osteoporosis			
Tuberculosis			
Other			
Other			

**PERSONAL/SOCIAL:**

Marital Status: S  M  D  W

Tobacco: Current Use: N  Y  Wish to Quit: N  Y

Prior Use: N  Y  # Years: \_\_\_\_\_ Stopped: \_\_\_\_\_

Alcohol Use: N  Y  Number of drinks per wk.: \_\_\_\_\_

Have you ever used alcohol or drugs to excess? N  Y

Have you ever considered decreasing/stopping? N  Y

Street Drugs: Current: N  Y  Ever Used: N  Y

Caffeine use: \_\_\_\_\_ servings per day

Total number of sexual partners you have had: \_\_\_\_\_

Did your mother take DES while she was pregnant with you? N  Y

How old were you when you began your sexual activity? \_\_\_\_\_

Physically/Sexually Abused: N  Y  Currently: N  Y

Exercise Regularly: N  Y  Type: \_\_\_\_\_

Employment: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

This area for office use only

Check yes to any problems and **CIRCLE YOUR PROBLEM**

**General:** (Fatigue, Wt. gain, Wt. loss, fevers) N  Y

**Eyes:** (Visual changes, Glaucoma) N  Y

**Ears/Nose/Throat:** (Hearing, Sinus, Oral lesions, and/or difficulty swallowing) N  Y

**Respiratory:** (Cough, Sputum production, Asthma, prior pneumonia, bloody sputum) N  Y

**Cardiovascular:** (Chest pain, Shortness of breath, palpitations, prior heart attack, etc.) N  Y

**Gastrointestinal:** (Nausea, Vomiting, Diarrhea, constipation, abdominal pain, food intolerance, ulcer, blood/mucus or change in stool) N  Y

**Urinary:** (Urinary tract infection, Urgency/frequency, bloody urine, loss of urine with cough/sneeze) N  Y

**Musculoskeletal:** (Arthritis, Injuries, Limitations) N  Y

**Skin/Breast:**(Change in mole or lesion,UV exposure to sun/tanner, breast change/discharge,excess hair growth) N  Y

**Neurological:** (Weakness, Numbness, Tingling, Seizures, Headaches, Etc.) N  Y

**Psychiatric:** (Depressed, Moody, Suicidal thoughts) N  Y

**Endocrine:** (Heat or cold intolerance, ↑ or ↓ in appetite, ↑ or ↓ in thirst or urination) N  Y

**Anemia:** ( Past anemia/blood disorders) N  Y

**Allergy/Immunization**(Food/insect allergies/HIV risk) N  Y

**Are there any other questions for your provider?** N  Y

<b>PATIENT SIGNATURE:</b>	<b>PROVIDER SIGNATURE</b>
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