Name: _____ **DOB:** _____ **Today's Date:** _____

Reason for visit / Main complaint:

_____

Medication(s) (Drugs, Pills, Vitamins and Supplements):

1. _____ 6. _____ 11._____
2. _____ 7. _____ 12. _____
3. _____ 8. _____ 13. _____
4. _____ 9. _____ 14. _____
5. _____ 10. _____ 15. _____

Medicine Allergies:

Surgeries / Dates:

Social History:

Do you drink alcohol? _____ Drinks per day? ____
Drinks per week? _____ per month? _____
Do you smoke? _____ Packs daily? ____ Years? ____
Do you use illicit drugs? _____
If yes, what kind? _____
Current Occupation/Employer: _____
What kind of work? _____
Marital Status: □ Single □ Divorced □ Married □ Widowed
Who lives with you? _____

Family History:

	Mother	Father	Sister	Brother
Asthma	□	□	□	□
Cancer	□	□	□	□
Colon Polyps	□	□	□	□
Colon Cancer	□	□	□	□
Heart Disease	□	□	□	□
Diabetes	□	□	□	□
Stroke	□	□	□	□
	Grandma (Maternal)	Grandma (Paternal)	Grandpa (Maternal)	Grandpa (Paternal)
Asthma	□	□	□	□
Cancer	□	□	□	□
Colon Polyps	□	□	□	□
Colon Cancer	□	□	□	□
Heart Disease	□	□	□	□
Diabetes	□	□	□	□
Stroke	□	□	□	□

Indicate if you are having any current problems, signs or symptoms in any of the following areas:

□ General Wellness □ Eyes □ Skin □ Other
□ Ears, Nose, Throat □ Stomach /Digestion □ Lungs/Breathing
□ Heart /Circulation □ Diarrhea /Constipation □ Neurological
□ Allergies □ Reproductive/Urinary □ Thyroid/Endocrine
□ Psychiatric □ Blood/Lymph □ Muscles/Joints/Bones

Physician Comments-ROS
□ *All other systems negative*