

Patient Name _____ Date _____

Reason for today's visit: (chief complaint) _____

Weight: _____ Shoe Size: _____

Current medications: _____

Allergies to medications: _____

Surgeries you have had: _____

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
Diabetes	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat/Mouth	___	___	_____
High blood pressure	___	___	_____
Heart (murmur, artificial valves)	___	___	_____
Lungs	___	___	_____
Stomach/bowel	___	___	_____
Kidneys	___	___	_____
Arthritis/muscles/joints	___	___	_____
Skin	___	___	_____
Psychological disorder	___	___	_____
Blood/bleeding disorder	___	___	_____
Allergic/immunologic	___	___	_____
Cancer	___	___	_____
Circulatory problems	___	___	_____
Liver disease	___	___	_____
Phlebitis	___	___	_____
Varicose veins	___	___	_____
Stroke	___	___	_____

Females: are you pregnant ___yes ___no planning to become pregnant ___yes ___no

Family History: (Past family & social history)

No. of children: _____ age(s) _____

Check the following medical conditions that have occurred in your family:

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Arthritis	___	___	___
Cancer	___	___	___
Diabetes	___	___	___
Eczema	___	___	___
Heart disease	___	___	___
High blood pressure	___	___	___
Lung disease	___	___	___
Malignant Melanoma	___	___	___
Skin cancer	___	___	___

Social History:

Who is your primary care or family doctor? _____

Do you live alone? ___no ___yes Do you smoke? ___no ___yes -frequency _____

Do you drink alcohol? ___no ___yes-frequency _____ Do you use recreational drugs? ___no ___yes-frequency _____

Occupation _____ Hobbies/leisure activities _____

Reviewed: _____ Date _____ Update _____