**Name:**_____ **Birthdate:**_____ **Date:**_____

## PATIENT HISTORY

Have you ever had or do you have….

| | | | |
|---|---|---|---|
| □ Alcoholism | □ Cancer:_____ | □ Kidney Disease | □ Other: _____ |
| □ Anemia | □ Diabetes | □ Liver Problem | _____ |
| □ Angina/Heart Attack | □ Emphysema | □ Lung Problem | _____ |
| □ Arthritis | □ Epilepsy/Seizures | □ Mental Illness | |
| □ Asthma /Hay Fever | □ Glaucoma | □ Stroke | |
| □ Birth Defects | □ Headaches | □ Thyroid Problem | |
| □ Bladder Disease | □ Heart Failure | □ Tuberculosis | |
| □ Bleeding Disorder | □ High Blood Pressure | □ Venereal Disease | |

Drug Allergies? _____

Current Medications? _____

Surgeries and Injuries: _____

## FAMILY HISTORY

Has anyone in your family had….

| | | | |
|---|---|---|---|
| □ Alcoholism | □ Cancer:_____ | □ Kidney Disease | □ Other: _____ |
| □ Anemia | □ Diabetes | □ Liver Problem | _____ |
| □ Angina/Heart Attack | □ Emphysema | □ Lung Problem | _____ |
| □ Arthritis | □ Epilepsy/Seizures | □ Mental Illness | |
| □ Asthma /Hay Fever | □ Glaucoma | □ Stroke | |
| □ Birth Defects | □ Headaches | □ Thyroid Problem | |
| □ Bladder Disease | □ Heart Failure | □ Tuberculosis | |
| □ Bleeding Disorder | □ High Blood Pressure | □ Venereal Disease | |

## SOCIAL HISTORY

Do you….

| | | | |
|---|---|---|---|
| □ Exercise regularly | □ Use Alcohol | □ Use Tobacco | □ Use Drugs |
| Type: _____ | Beer/Wine/Liquor | Cigarettes/Cigars/Pipe | Marijuana/Heroin/ |
| How Often: _____ | How Often: _____ | Snuff/Chew Tobacco | Cocaine/LSD/Crack |

***FOR OFFICE USE ONLY --- DATE REVIEWED:*** _____

# PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: □ Healthy □ Not Healthy □ Other: _____

**Have you ever experienced or are you experiencing any of the following: (Please check all that apply)**

| | | | |
|---|---|---|---|
| Ears, Nose, Throat, & Mouth | □ Itching | □ Nose Blocked | □ Post Nasal Drip |
| | □ Rhinitis (Runny Nose) | □ Sores in mouth | □ Teeth Hurt |
| | □ Bruxism (Grinding Teeth) | □ Difficulty Swallowing | □ Painful Swallowing |
| | □ Pressure in Ears | □ Other: _____ | □ None |
| Cardiovascular (Heart) | □ Palpitations/Fluttering of Heart | □ Pain in chest | □ Shortness of breath while exercising |
| | | □ Other: _____ | □ None |
| Respiratory (Lungs) | □ Wheezing | □ Shortness of breath while sitting | □ Cough |
| | | □ Other: _____ | □ None |
| Gastrointestinal (Stomach) | □ Constipation | □ Diarrhea | □ Pain |
| | □ Reflux | □ Other: _____ | □ None |
| Genitourinary | □ Hesitation when urinating | □ Urination at night | |
| | | □ Other: _____ | □ None |
| Musculoskeletal | □ Soreness | □ Weakness | □ Cramping |
| | | □ Other: _____ | □ None |
| Integumentary (Skin) | □ Itchy Skin | □ Lesions on Skin | □ Bleeding |
| | □ Dry Skin | □ Other: _____ | □ None |
| Neurological (Nerves) | □ Twitch | □ Ringing of Ears | □ Dizziness/Vertigo |
| | □ Abnormal Movements | □ Other: _____ | □ None |
| Psychiatric | □ Mood Swings | □ Situation Stress | □ Change |
| | □ Depression | □ Other: _____ | □ None |
| Endocrine | □ Hot Flashes | □ Hair Loss/Growth | □ Heat |
| | □ Cold | □ Other: _____ | □ None |
| Hematologic/Lymph Nodes | □ Bleeding Easily | □ Night Sweats | |
| | | □ Other: _____ | □ None |
| Allergic/Immunologic | □ Sneezing | □ Eye Irritation | □ Reactions |
| | | □ Other: _____ | □ None |