



**SOCIAL AND FAMILY HISTORY**

Have you ever smoked?  Yes  No Quantity/Amount: \_\_\_\_\_ If quit, how long ago? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No Number per week \_\_\_\_\_ Has anyone ever told you to cut down on your drinking?  Yes  No  
 Do you use recreational drugs, such as marijuana, cocaine, meth?  Yes  No If yes, please list \_\_\_\_\_

Do you know of any blood relative who has or had any of the following? (Check and indicate relationship)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Cancer _____<br>Type _____ | <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Tuberculosis _____       |
| <input type="checkbox"/> Leukemia _____             | <input type="checkbox"/> High Blood pressure _____ | <input type="checkbox"/> Osteoarthritis _____       | <input type="checkbox"/> Diabetes _____           |
| <input type="checkbox"/> Stroke _____               | <input type="checkbox"/> Bleeding tendency _____   | <input type="checkbox"/> Asthma _____               | <input type="checkbox"/> Goiter _____             |
| <input type="checkbox"/> Colitis _____              | <input type="checkbox"/> Alcoholism _____          | <input type="checkbox"/> Psoriasis _____            | <input type="checkbox"/> Autoimmune Disease _____ |

**SYSTEM REVIEW**

As you review the following list, please check any of those problems, which have significantly affected you.

<input type="checkbox"/>	<b>CONSTITUTIONAL</b>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>	<input type="checkbox"/>	<b>INTEGUMENTARY (SKIN)</b>
<input type="checkbox"/>	Recent weight <input type="checkbox"/> gain or <input type="checkbox"/> loss Amount: _____	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	Fatigue Weakness Fever	<input type="checkbox"/>	Vomiting of blood or coffee ground material	<input type="checkbox"/>	Redness
<input type="checkbox"/>	<b>EYES</b>	<input type="checkbox"/>	Stomach pain relieved by food or milk	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	Abnormal stools	<input type="checkbox"/>	Hives
<input type="checkbox"/>	Double or blurring vision	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	<b>EARS -NOSE-MOUTH-THROAT</b>	<input type="checkbox"/>	Persistent diarrhea	<input type="checkbox"/>	Tightness
<input type="checkbox"/>	Ringling in ears	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Nodules/bumps
<input type="checkbox"/>	Loss of Hearing	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Color changes of hands or feet in the cold
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Increasing constipation	<input type="checkbox"/>	<b>NEUROLOGICAL SYSTEM</b>
<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	Lactose Intolerance	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Dryness of mouth	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Difficulty in swallowing	<input type="checkbox"/>	<b>GENITOURINARY</b>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<b>CARDIOVASCULAR</b>	<input type="checkbox"/>	Painful or difficult urination	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Pain in chest	<input type="checkbox"/>	Blood or pus in urine	<input type="checkbox"/>	Sensitivity or pain of hands and/or feet
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Cloudy "smoky" urine	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	Discharge from penis/vagina	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Getting up at night to pass urine	<input type="checkbox"/>	Muscle spasm
<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	Loss of consciousness
<input type="checkbox"/>	Morning stiffness	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<b>HEMATOLOGIC/LYMPHATIC</b>
<input type="checkbox"/>	Lasting how long? _____	<input type="checkbox"/>	<b>RESPIRATORY</b>	<input type="checkbox"/>	Transfusion? When
<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	Difficulty in breathing at night	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	Muscle tenderness	<input type="checkbox"/>	Wheezing (asthma)	<input type="checkbox"/>	Tender glands
<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	Swollen legs or feet	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Which Joints _____	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<b>PSYCHIATRIC</b>
<input type="checkbox"/>	<b>ALLERGIC/IMMUNOLOGIC</b>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	Frequent sneezing	<input type="checkbox"/>	<b>ENDOCRINE</b>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Increased susceptibility to infection	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	Difficulty falling asleep
		<input type="checkbox"/>		<input type="checkbox"/>	Difficulty staying asleep

Patient's Name: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_ Physician Initials: \_\_\_\_\_