Name: (Last, First, Middle) _____ **Account #** _____

Illnesses - Please list all major illnesses

Surgeries - Please list any surgical procedures

Procedure	Year	Prodcedure	Year

Medications - Please list **ALL CURRENT** medicines

Medications	How Much / How Often	Medications	How Much / How Often
Aspirin			

Allergies - Please list all MEDICATION allergies

Social History

smoking	N Y	I smoke(d) _____ packs/day for _____ years **OR** I quit for _____ years
alcohol	N Y	I have _____ drinks/day **OR** I drink socially (less than 3 drinks/week)

Family Medical History

Father:
Mother:
Other:

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Review of Systems Do you **CURRENTLY** have any problems related to the following systems? Circle Y(es) or N(o).

General		**Respiratory**		**Gastrointestinal**		**Urological**		**Hematologic/Lymphatic**	
Fever	Y N	Wheezing	Y N	Stomach Pain	Y N	Urinate often	Y N	Swollen Gland	Y N
Chills	Y N	Cough	Y N	Nausea	Y N	Painful Urinaltion	Y N	Bleeding Prob.	Y N
Headache	Y N	Short of Breath	Y N	Vomiting	Y N	Urinate Slowly	Y N	Other	Y N
Other	Y N	Other		Indigestion	Y N	Urinate at Night	Y N		
				Other	Y N	Urinary Leakage	Y N	**Allergy/Immunology**	
Eyes		**Musculoskeletal**				Incomplete Emptying	Y N	Hay Fever	Y N
Blurred Vision	Y N	Joint Pain	Y N	**Endocrine**		Other	Y N	Drug Allergy	Y N
Double Vision	Y N	Neck Pain	Y N	Too Thirsty	Y N			Other	Y N
Pain	Y N	Back Pain	Y N	Too Hot/Cold	Y N	**Neurological**			
Other	Y N	Other	Y N	Tiredness	Y N	Tremors	Y N	**Psychological**	
				Other	Y N	Dizzy Spells	Y N	Depression	Y N
Ear/Nose/Throat/Mouth		**Cardiovascular**				Numbness	Y N	Other	Y N
Ear Infection	Y N	Chest Pain	Y N	**Skin**		Tingling	Y N		
Sore Throat	Y N	Palpitations	Y N	Skin Rash	Y N	Other	Y N		
Sinus Problem	Y N	Hypertension	Y N	Persistent Itch	Y N				
Other	Y N	Other	Y N	Other	Y N				

Physician use only: (Notes/Comments)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

Physician Signature _____ Date _____