

NAME _____

MARITAL STATUS : DO YOU DRINK ALCOHOL? YES NO DO YOU SMOKE? YES NO

MARRIED SINGLE OCCASIONAL 1 PER DAY OCCASIONAL ½ PK PER DAY

WIDOWED DIVORCED 2-3 PER DAY 4+ PER DAY 1 PK PER DAY 1+ PK PER

REVIEW OF SYSTEMS

HAVE YOU RECENTLY HAD ANY PROBLEMS WITH OR ARE YOU CURRENTLY UNDER TREATMENT FOR ANY OF THE FOLLOWING?

| | YES | NO | EXPLANATION OF PROBLEM |
|---|--------------------------|--------------------------|------------------------|
| PREGNANT OR NURSING (DUE DATE) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GENERAL/CONSTITUTIONAL (FEVER, WEIGHT LOSS) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| EARS, NOSE, THROAT (SINUS, EAR INFECTION, COUGH, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| CARDIOVASCULAR (HEART, VESSELS, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| RESPIRATORY (ASTHMA, EMPHYSEMA, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GASTROINTESTINAL (STOMACH, ULCERS, INTESTINAL DISEASE,ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GENITAL, KIDNEY, BLADDER (INFECTION, STONES, PROSTATE, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| MUSCLES, BONES, JOINTS (ARTHRITIS ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| SKIN (ACNE, WARTS, SKIN CANCER, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| NEUROLOGICAL (MULTIPLE SCLEROSIS, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| PSYCHIATRIC (ANXIETY, DEPRESSION, INSOMNIA) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ENDOCRINE (DIABETES, THYROID, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| BLOOD/ LYMPH (CHOLESTEROL, ANEMIA, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ALLERGIC/ IMMUNOLOGIC (HAYFEVER, LUPUS, SJOGRENS, ETC.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

FAMILY HISTORY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD PROBLEMS WITH ANY OF THE FOLLOWING? IF YES, PLEASE STATE THEIR RELATIONSHIP TO THE PATIENT. IF YES, PLEASE STATE THEIR RELATIONSHIP TO THE PATIENT. M= MOTHER F= FATHER S= SIBLING GP =GRANDPARENT

| | YES | NO | RELATIONSHIP TO PATIENT |
|--------------------------------------|--------------------------|--------------------------|-------------------------|
| BLINDNESS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| CANCER | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| HEART DISEASE OR HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| KIDNEY DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| LUPUS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| STROKE | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| THYROID | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| OTHER | <input type="checkbox"/> | <input type="checkbox"/> | _____ |