



PATIENT DEMOGRAPHICS

Review of Systems: Please circle all responses that apply to today's visit:

Constitutional:	Fever Sweats	Weight loss/gain	Fatigue	Night sweats
Ears, Nose, Throat:	Mouth sores Voice change Hoarseness	Hearing loss/ringing Bleeding gums Swollen glands in neck	Earaches/drainage Bad breath/taste Chronic sinus problems	Nose bleeds Sore throat Snoring
Respiratory:	Cough Spitting/coughing up blood	Asthma Tuberculosis	Wheezing Pneumonia	Shortness of breath
Cardiovascular:	Calf pain Palpitations	Rapid heart beat Swelling of Feet/ankles/hands	Chest pain/angina Pacemaker	Heart murmur
Gastrointestinal:	Ulcers Rectal bleeding Difficulty Swallowing	Nausea Change in bowel habits Jaundice Gall bladder problems	Vomiting Painful bowel movements Abdominal Pain	Heartburn Diarrhea Constipation Appetite loss
Genitourinary:	Difficult urination Incontinence/Dribbling	Impotence Testicular Pain	Menstrual pain Kidney stones	Frequent urination Bloody urine
Musculoskeletal:	Bone pain weakness Joint Pain	Muscle Pain Back Pain	Leg Pain Stiffness	Difficulty walking Swelling
Integumentary: (Skin, Breast)	Change in Hair/Nails Skin Cancer Varicose veins	Rashes Unusual looking lesions Breast pain	Itching Ulcers Breast lump	Changes in skin color Easy bruising Nipple discharge
Neurological:	Tremors Tingling/numbness Meningitis	Dizziness Migraines/headaches Memory loss	Seizures Head injury Paralysis	Stroke Fainting
Psychiatric:	Memory Loss Anxiety	Insomnia	Depression	Mood swings
Endocrine:	Excessive thirst	Excessive urination	Heat intolerance	Cold intolerance
Hematological, Lymphatic:	Phlebitis Bruising easy	Anemia Bleeding problems	Past transfusion Blood clots	Large lymph nodes
Allergic, Immunology:	Seasonal allergies Hives	Frequent colds Sneezing	Runny nose	Itchy eyes

Breast Questionnaire: \_\_\_\_\_

Medical Assistant Initials \_\_\_\_\_

**SURGICAL HISTORY**

List Previous surgery and procedures: (What, When, Where and Type of Anesthesia)

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**PERSONAL AND FAMILY HISTORY**

Check any of the following that apply to you or your family and explain in detail in the remarks section with dates and treatments.

	Me	Fam			Me	Fam	
Atrial Fibrillation				Breast Cancer			
Angina				Lung Cancer			
Heart Attack				Colon Cancer			
Heart Disease				Prostate Cancer			
Mitral valve prolapse				Other Cancer			
High Cholesterol				Radiation Therapy			
High Lipids				Chemotherapy			
High Blood Pressure				Prostate enlargement			
Coumadin therapy				Internal bleeding			
Pacemaker Implant				Seizure Disorder			
Stroke				Major Trauma			
Emphysema				Bleeding Problems			
Pneumonia				Orthopaedic Problem			
Asthma				Arthritis			
Colitis				Joint Disease			
Difficulty Eating				Mental Illness			
Gerd				Unexplained Weight Loss			
Diabetes				AIDS/HIV			
Kidney Disease				Anesthesia Problems			
Hepatitis				Alcoholism			
Thyroid Disease							

Remarks: (Please explain any boxes you checked)

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TOBACCO USE

	YES	NO	AMOUNT/NUMBER OF YEARS	WHEN DID YOU QUIT?
Alcohol Use:				
Tobacco Use:				
Cigarette:				
Cigar:				
Pipe:				
Oral/Snuff:				
Drug Use:				

ALCOHOL and DRUG USE

Alcohol	YES	NO	AMT per DAY/# OF YEARS	WHEN DID YOU QUIT?
Current				
Previous				
Never				
Drugs			TYPE	WHEN DID YOU QUIT?
Current				
Previous				
Never				

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_