DATE: _____ AGE: _____

PATIENT: _____ SEX: M F

HEIGHT: _____ WEIGHT: _____

REASON FOR VISIT TODAY: _____

HISTORY OF PRESENT ILLNESS:

When did the condition first occur? _____

_____

_____

_____

Date of last exam by your Primary Care Physician or Internist: _____

Allergies (include reaction): _____

_____

Current Medications (please include aspirin, ibuprofen, birth control pills, etc. and dosage):

_____

_____

Medical Illnesses: _____

_____

Previous Surgeries: _____

_____

FAMILY & SOCIAL HISTORY:

Occupation: _____ Spouse Occupation: _____

Marital Status: _____ No. of Children: _____

History of Family Illnesses: _____

_____

_____

Alcohol Use (describe type & amount): _____

Never Occasionally Daily Weekly

Tobacco Use (describe type & amount): _____

Never Occasionally Daily Weekly

Special Diet (describe type &amount): _____

Never Occasionally Daily Weekly

REVIEW OF SYSEMS:

Please indicate any history of problems with the following:

	Yes/No		Yes/No		Yes/No
Weight Loss/Gain	☐ ☐	Heartburn	☐ ☐	Fainting/Dizziness	☐ ☐
Fever/Chills	☐ ☐	Reflux	☐ ☐	Stroke	☐ ☐
Thyroid	☐ ☐	Indigestion	☐ ☐	Seizures	☐ ☐
Cough	☐ ☐	Nausea/Vomiting	☐ ☐	Depression/Anxiety	☐ ☐
Shortness of Breath	☐ ☐	Hernia	☐ ☐	Hepatitis	☐ ☐
Palpitations	☐ ☐	Jaundice	☐ ☐	Implants	☐ ☐
Chest Pain	☐ ☐	Urinary Symptoms	☐ ☐	Skin or Breast Mass	☐ ☐
High Blood Pressure	☐ ☐	Change in Bowel Habit	☐ ☐	Abnormal Mouth	☐ ☐
Arthritis	☐ ☐	Hemorrhoids	☐ ☐	Ear, Nose,	☐ ☐
Abdominal Pain	☐ ☐	Anemia	☐ ☐	Diabetes	☐ ☐
Ulcer	☐ ☐	Bleeding	☐ ☐	Cancer	☐ ☐

If answered yes to any of the above, please describe in detail:

_____

_____

_____

_____

PHYSICIAN COMMENTS:

_____

_____

_____

Patient Signature: _____

Attending Physician: _____