

Patient to fill out this entire side of form. Other side is for Doctor use only.

Patient Name \_\_\_\_\_ The Name I prefer to be called: \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

Current medications: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Reason for today's visit: (Chief Complaint) \_\_\_\_\_

Location of problem: \_\_\_\_\_ How long have you had it? \_\_\_\_\_  
(days/weeks/months/years)

Symptoms \_\_\_\_\_ Severity of problem: \_\_\_\_\_  
(eg, itching/bleeding/pain) (eg, mild/moderate/severe)

Does anything make it better or worse? \_\_\_\_\_  
(eg, over the counter medications)

Does it come/go at a time of day? \_\_\_\_\_

**Current or past problems with: (Review of systems)**

|                          | Yes                      | No                       | (If yes explain) |
|--------------------------|--------------------------|--------------------------|------------------|
| General health           | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Eyes                     | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Eyes/Nose/Throat/Mouth   | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Heart                    | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Lungs                    | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Stomach/Bowel            | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Kidneys                  | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Arthritis/muscles/joints | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Skin                     | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Headaches/seizures       | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Psychological disorder   | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Thyroid/Diabetes         | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Blood/bleeding disorder  | <input type="checkbox"/> | <input type="checkbox"/> | _____            |
| Allergic/immunologic     | <input type="checkbox"/> | <input type="checkbox"/> | _____            |

Females: are you pregnant?  Yes  No Planning to become pregnant?  Yes  No

**Family History: (Past family & social history)**

Mother: living/deceased \_\_\_\_\_ age \_\_\_\_\_ Father: living/deceased \_\_\_\_\_ age \_\_\_\_\_

Number of children you have \_\_\_\_\_ age(s) \_\_\_\_\_

**Check the following medical conditions that have occurred in your family:**

| Disease   | Mother                   | Father                   | Blood                    | Relative                 | Disease             | Mother                   | Father                   | Blood                    | Relative                 |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malignant Melanoma  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hayfever  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Social History:**

Do you live alone? No Yes  
Do you drink alcohol? No Yes - frequency \_\_\_\_\_  
Occupation \_\_\_\_\_  
Do you smoke? No Yes Frequency \_\_\_\_\_  
Do you use recreational drugs? No Yes - frequency \_\_\_\_\_  
Hobbies/leisure activities \_\_\_\_\_