Patient Name:_____ Age:_____ Date:_____

Allergies:_____

Current medications:_____

Reason for today's visit (chief complaint)

_____

_____

Current or past problems with: **YES** **NO** ***if yes, please explain***

General Health	_____
Eyes	_____
Ears/nose/throat/mouth	_____
Heart/blood/vessels	_____
Lungs	_____
Stomach/bowel	_____
Kidney	_____
Arthritis/muscles/joints/bones	_____
Skin	_____
Headaches/seizures/neurological	_____
Psychological disorder	_____
Thyroid/diabetes/endocrine	_____
Blood/bleeding disorder	_____
Allergic/immunologic	_____
Hepatitis C	_____
HIV	_____

Females: Are you pregnant? Yes No Are you planning on becoming pregnant? Yes No

Are you taking hormones or birth control pills? Yes No

Family History

Children? Yes No If yes, how many? _____ Ages:_____
Mother: Living-Current Age _____ Deceased-Age at death _____
Father: Living-Current Age _____ Deceased-Age at death_____
Are any family members currently patients of this practice? Yes No if yes, their names:_____

Check any medical conditions that occur/have occurred in your family:

	MOTHER	FATHER	BLOOD RELATIVE		MOTHER	FATHER	BLOOD RELATIVE
Allergies	_____	_____	_____	Heart Disease	_____	_____	_____
Arthritis	_____	_____	_____	High Blood Pressure	_____	_____	_____
Asthma	_____	_____	_____	Lung Disease	_____	_____	_____
Cancer	_____	_____	_____	Malignant melanoma	_____	_____	_____
Diabetes	_____	_____	_____	Psoriasis	_____	_____	_____
Eczema	_____	_____	_____	Skin Cancer	_____	_____	_____
Hayfever	_____	_____	_____	Tuberculosis	_____	_____	_____

Social History

Height_____ **Weight**_____ **Do you live alone?** **Yes** **No**

Do you smoke? **Yes** **No** **Do you drink alcohol?** **Yes** **No**

Do you use recreational Drugs? **Yes** **No**

Hobbies/leisure activities: _____