Patient Name:_____ Med Rec-#:_____

CHRONIC PROBLEMS LIST: Please list any **chronic** health problems you have

Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you:

Diagnosis:	Yes	No	Relationship:		Diagnosis:	Yes	No	Relationship
Blood disease					High Cholesterol			
BPH					High Blood Pressure			
Cancer					Inflammatory bowel disease			
Type:					Migraines			
CVA / Stroke					Renal failure			
Coronary artery disease					Seizure disorder			
Diabetes					Thyroid disorder			
Eczema					Urinary tract infections			
Gout					Kidney stones			
Hearing Impairment					**Other:**			
Other:								

Marital/Family Status:

Current Status: ☐Single ☐Married ☐Divorced ☐Widowed Previously widowed? ☐Yes ☐No Previous divorce?☐Yes ☐No
Do you have children? ☐Yes ☐No If so, number: _____

LIFESTYLE:

Occupation: _____
Exercise? ☐Yes ☐No If yes, Type:_____ Frequency:_____ per _____ Hours per week: _____

TOBACCO:

Uses tobacco? ☐Yes ☐No ☐Former Tobacco type: _____ Units per day: _____ Number of years: _____
If former user: Units per day: _____ Number of years: _____ Year quit: _____

CAFFEINE: ☐Yes ☐No **ALCOHOL:** ☐Yes ☐No ☐formerly Year quit: _____

Type: _____, _____ Type: _____ Frequency: _____
Amount daily: _____ Amount: _____ per _____ Last drink: _____

REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--☐Neg
No Yes
○ ○ chills
○ ○ fever

Respiratory--☐Neg
No Yes
○ ○ dyspnea (shortness of breath)

Gastrointestinal-☐Neg
No Yes
○ ○ diarrhea

Metabolic/Endocrine--- ☐Neg
No Yes
○ ○ goiter

Musculoskeletal-☐Neg
No Yes
○ ○ back pain

Heent---☐Neg
No Yes
○ ○ double vision

Cardiovascular--☐Neg
No Yes
○ ○ chest pain

Integumentary--☐Neg
No Yes
○ ○ rash

Neurological--☐Neg
No Yes
○ ○ dizziness

Hema/Lymphatic-☐Neg
No Yes
○ ○ easy bleeding
○ ○ petechiae/easy bruising

Psychiatric--☐Neg
No Yes
○ ○ anxiety

11 System ROS
☐ All Negative

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