Current Medications/Over the Counter Medication

☐ NONE

Name of Medication	Dose	Frequency Taken	Reason Taken	Prescribing Physician

Medical History

☐ NONE

Date (Month/Year)	History (Heart Disease, Hypertension, Diabetes, Etc.)

Allergies

☐ NO KNOWN ALLERGIES

Agent/Substance	Type of Reaction

Surgical History

☐ NONE

Date (Month/Year)	Surgery

Hospitalization

☐ NONE

Date (Month/Year)	Reason for Hospitalization

Family History

Family Member	Year Of Birth/ Age	Deceased		Medical History
Father		Yes	No	
Mother		Yes	No	
Paternal Grandfather		Yes	No	
Paternal Grandmother		Yes	No	
Maternal Grandfather		Yes	No	
Maternal Grandmother		Yes	No	
Siblings		Yes	No	

Siblings

How many: Brothers _____ Sisters_____

Children

How many: Sons _____ Daughters_____

Social History

Smoking Status
Are you a:

- ☐ Current tobacco user
- ☐ Former tobacco user
- ☐ Non tobacco user
- ☐ Current some day tobacco user

If current user: How often do you use tobacco?

- ☐ every day
- ☐ some days, but not every day

If current tobacco user: How many times a day do you use tobacco?

- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or more

If current tobacco user: How soon after you wake up, do you use tobacco?

- ☐ within 5 min
- ☐ 6-30 min
- ☐ 31-60 min
- ☐ after 60 min

If current tobacco user: Are you interested in quitting?

- ☐ Ready to quit
- ☐ Thinking about quitting
- ☐ Not ready to quit

If you are a former user:
How long has it been since you used tobacco?

- ☐ 1-3 months
- ☐ less than 1 month
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-5 years
- ☐ 5- 10 years
- ☐ more than 10 years

Household Exposure to Smoke

- ☐ No
- ☐ Yes

Alcohol Use

Did you Have a drink in the last year: ☐ Yes ☐ No

How often did you have a drink in the last year

- ☐ Never
- ☐ Monthly or Less
- ☐ Two or four times a month
- ☐ Two to three times a week
- ☐ Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 or 9
- ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

REVIEW OF SYSTEMS

Please check any of the following problems you have had in the last six months

General

- o NONE
- o Headaches
- o Temperament
- o Change in Appetite
- o Sleep Problems
- o Fatigue
- o Fever

HEENT/NECK

- o NONE
- o Swollen Glands
- o Difficulty with Hearing
- o Dental Infections
- o Bleeding gums
- o Dizziness
- o Change in Vision
- o Drooping Eyelids
- o Ear Pain
- o Fullness in ear
- o Ringing in Ear
- o Allergies
- o Cough
- o Epistaxis (Nasal bleeding)
- o Loss of Smell
- o Sinus pain/problems
- o Difficulty Swallowing
- o Hoarseness
- o Snoring
- o Change in voice
- o Sore Throat
- o Swollen lymph nodes
- o Bad breath/taste

Urology

- o NONE
- o Frequency
- o Dysuria (Painful Urination)
- o Blood in Urine
- o Burning on Urinating
- o Difficult Urinating

Endocrine

- o NONE
- o Feels cold
- o Hair Loss
- o Low blood pressure
- o Tiredness
- o Bleeding Disorder

Respiratory

- o NONE
- o Sleep Apnea
- o Coughing up blood
- o Dry Mouth
- o Shortness of breath
- o Wheezing

Neurological

- o NONE
- o Seizures
- o Memory Changes
- o Numbness/tingling
- o Weakness
- o Unbalanced walking

Hematologic

- o NONE
- o Abnormal bleeding
- o Prior Transfusion
- o Easy Bruising
- o Swelling in Neck
- o Platelet Disorder
- o Anemia

Cardiology

- o NONE
- o High Blood Pressure
- o High Cholesterol
- o Chest Pain
- o Fainting

Gastrointestinal

- o NONE
- o Reflux
- o Pain in Stomach
- o Epigastric Pain
- o Heartburn
- o Nausea
- o Change in appetite
- o Diarrhea
- o Constipation
- o Black Stools
- o Blood in stools

Musculoskeletal

- o NONE
- o Joint Swelling
- o Joint Pain
- o Stiffness
- o Trauma
- o Falls