

MEDICAL/FAMILY/SOCIAL HISTORY (PAGE 1 OF 2)

Name: _____ Today's Date: _____

SS#: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today?

Current problem is the result of a (n): Check all that apply

Car Accident Work Accident Injury Other _____

This occurred during: (Check all that apply)

Lifting Pulling Twisting Falling Bending Reaching
 Squatting Hit By Object Not Known Chronic

Past Medical History

Surgeries/Hospitalization	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had general anesthesia? No Yes

If yes, did you have any problems with anesthesia? No Yes

If yes, please describe: _____

Medications	Dose	How Long?	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: Antibiotic agents _____ Penicillin's Latex Drugs _____

(Check all that apply) Sulfur Dust/Pollens Other: _____

Name: _____

SS#: _____

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Review of Systems

Are you currently having or have you had problems with: (If yes please describe)

Eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ears, Nose, Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lung, Breathing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Digestion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bowel Movement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bladder Problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bleeding Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Balance Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Numbness/tingling	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Blackout/fainting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Psychological Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Kidney	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
TB	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Family History

Member	Alive	Deceased	Age	Health Status or cause of death
Grandmother (mom's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (mom's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandmother (dad's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (dad's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Social History

Please check: Employed (occupation _____) Work in the home Student
 Single Married Divorced Separated Widowed
 Children No Yes - #:

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special diet? No Yes Describe: _____

History of substance abuse? No Yes What? _____

Smoke currently? No Yes _____ Packs per day for _____ years. Previously smoked? No Yes

Drink alcohol? No Yes Frequency _____ Type: _____

Reviewed by: _____ MD Date: _____