

¥ Do you smoke? YES / NO How much? _____

¥ Do you use recreational drugs? YES / NO

¥ How often do you drink alcohol? _____

¥ Are You Pregnant? YES / NO

¥ Are You Nursing? YES / NO

¥ Do you use a wheel chair, walker or cane? YES / NO

| LIST PAST OPERATIONS | General Dates |
|----------------------|---------------|
| | |
| | |
| | |
| | |
| | |

| PAST MEDICAL HISTORY Have you been treated for any of the following? List specific type. | | | |
|--|--|-------------------------|--|
| Diabetes | | Epilepsy | |
| Gout | | Developmental Disorder | |
| Heart Disease | | Mental Diseases | |
| Heart Attack | | Emphysema | |
| Arthritis | | Hepatitis | |
| Asthma | | Lung Disease | |
| Tuberculosis | | Thyroid Disease | |
| Stroke | | Bleeding Disorder | |
| Cancer | | High Blood Pressure | |
| Kidney Disease | | Neuro-Muscular Disorder | |
| HIV | | Anemia | |

| REVIEW OF SYSTEMS Are you currently experiencing any of the following? | | | |
|--|-----------------|---------------------|-------------------|
| GI | M S | N R | ENT |
| Heartburn | Weight Change | Numbness | Hearing Loss |
| Difficulty Swallowing | Joint Disease | Dizziness | Sore Mouth |
| Vomiting | Muscle Pain | Muscle Jerking | Speech Difficulty |
| Stomach Trouble | Joint Pain | Convulsions | Sore Throat |
| Stomach Ulcers | Stiffness | Weakness | Dental Problems |
| Excessive Thirst | Sciatica | Headaches | Ear Discharge |
| Abdominal Pain | Club Foot | C V | Ear Pain |
| Change in Stool | Fractures | Chest Pain | Nose Bleeding |
| Liver Trouble | Sprains | Prolonged Bleeding | |
| Difficulty Chewing | D M | Rapid Heartbeat | |
| Nausea | Itching | Pain Over Heart | |
| Diarrhea | Skin Rash | High Cholesterol | |
| Irritable Bowel | Moles | Varicose Veins | |
| Constipation | Eczema | Swelling | |
| G U | Psoriasis | Leg Pain or Cramps | |
| Bladder Trouble | Discolorations | Heart Problems | |
| Kidney Stones | Hives | R P | |
| Prostate Trouble | Bruises | Persistent Cough | |
| Change in Urine | Ulcerations | Lung Problems | |
| Excessive Urination | E Y | Coughing Phlegm | |
| Change in Urine | Eye Irritation | Wheezing | |
| Difficult Urination | Eye Injury | Difficult Breathing | |
| Frequent Urination | Impaired Vision | Coughing Blood | |
| Painful Urination | Eye Disease | Bronchitis | |