



**Illnesses**

- Diabetes     Heart Disease     Asthma     High Blood Pressure     Emphysema     Stroke  
 Cancer     Arthritis     COPD     High Cholesterol     CHF     Sleep Apnea (C-Pap machine?)  
 None or *List Others*
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**Surgery**

- Tonsils     Appendectomy     Heart     Gallbladder     None or *List Others*
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<b>Family History</b>	Relationship to Patient				Relationship to Patient							
	Y	N	Mother	Father	Sibling	Grandparent	Y	N	Mother	Father	Sibling	Grandparent
Blindness												
Glaucoma												
Arthritis												
Cancer												
Diabetes												

<b>Review of Systems</b>	Y	N	<b>If YES, Please Explain</b>
General / Constitutional (fever, weight loss, obesity, etc)			
Integumentary / Skin (rashes, growths, hair loss, etc)			
Ears (hearing loss, drainage, etc)			
Neck (swollen glands, thyroid, etc)			
Respiratory (congestion, wheezing, COPD, etc)			
Cardiovascular (high B/P, racing pulse, etc)			
Gastrointestinal (stomach upset, diarrhea, constipation, etc)			
GenitoUrinary (painful or frequent urination, impotence, etc)			
MusculoSkeletal (joint pain, stiffness, swelling, cramps, etc)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc)			
Hemato-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia, etc)			

Do you drink alcohol? If Yes:  occasionally     1/day     2-3/day     4+/day  
 Do you smoke? If Yes:  occasionally     1/2 pack/day     1 pack/day     1+packs/day

Current Occupation: \_\_\_\_\_

Patient Signature: \_\_\_\_\_