Name:_____Date:_____
Age:_____Height:_____Weight:_____Sex: M or F
Race:_____Occupation:_____
Family Doctor's name:_____

Marital Status:_____ # of Children:_____

Alcohol Use? Yes or No How Often? _____ How Much? _____
Tobacco or Chew Use? Yes or No Packs per day?___ How many years?____

REVIEW OF SYSTEMS

Please check all that apply to you

Cardiovascular
__Heart Disease
__Stroke
__Hypertension
__Heart Attack

Skin
__ Rash
__Psoriasis
__Ulcerations

Endocrine
__Diabetes
__Insulin
__Thyroid

GU
__Kidney disease
__Blood in Urine
__Pain in urination

GI
__Ulcers
__Abdominal Pain
__Constipation
__Diarrhea
__Cirrhosis

MISC.
__Cancer
__Lupus
__Sickle Cell
__HIV
__HEPATITIS

Eye
__Cataracts
__Blurred Vision
__Glasses/ Contacts
__Vision Loss
__Glaucoma

RESPIRATORY
__Short of Breath
__Emphysema
__Wheezing
__Asthma
__COPD

NEUROMISC
__Burning
__Numbness
__Headaches

MUSCULOSKELETAL
__ Arthritis ___ Prior Fracture

__ Rheumatic Fever __Gout

__Back Pain __Osteoporosis

MEDICINES:_____
_____
_____
_____

_____

ALLERGIC TO MEDICINE: _____
SURGERY HISTORY: _____
FAMILY HISTORY (CIRCLE ANY THAT APPLY)
Diabetes Circulatory Bleeding Disorder High Blood Pressure Foot Disorders