CHIEF COMPLAINT/HISTORY OF ILLNESS:
1. What is the reason for today's visit? 
2. How long have you had this problem? 
3. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10 mild
   very severe 
4. How often does this problem occur? □ constant □ comes and goes 
5. What makes it better? 
6. What makes it worse? 
7. What other symptoms are you having? 

PAST MEDICAL HISTORY (Please check any illnesses you have):
□ High blood pressure □ Asthma/Emphysema □ Rheumatic fever
□ Kidney disease □ Stroke, mini-stroke □ Sinusitis
□ Diabetes □ Heart disease/Angina □ Peptic ulcers
□ Neck/Back disease □ Hepatitis/Liver disease □ Thyroid disease
□ Cancer (please list type and date diagnosed): 

PAST SURGICAL HISTORY (Please check any surgeries you have had):
□ Heart bypass/valve □ Gall bladder □ Prostate removal
□ Coronary angioplasty □ Lung surgery □ Colon removal
□ Carotid artery surgery □ Joint replacement □ Appendix removal
□ Vascular bypass □ Back surgery □ Sinus surgery
□ Mastectomy □ Brain surgery □ Tonsillectomy
□ Heart transplant □ Liver transplant □ Kidney transplant

MEDICATIONS (List all your current medications and the dose you take):
Medication __________________________ Dose __________________________
Medication __________________________ Dose __________________________
Medication __________________________ Dose __________________________

Do you take Aspirin or Ibuprofen? □ Yes □ No
Do you take Warfarin (Coumadin)? □ Yes □ No
Have you taken steroids within the past year? □ Yes □ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):
Medication __________________________ Reaction __________________________
Medication __________________________ Reaction __________________________
Medication __________________________ Reaction __________________________

FAMILY HISTORY (Check all illnesses that run in your family):
□ Hearing loss □ Alcoholism □ Heart attack
□ High blood pressure □ Psychiatric illness □ Cancer
□ Sickle cell anemia □ Bleeding problems □ Diabetes
□ Poor circulation □ Anesthesia reaction □ Stroke

Others __________________________

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SOCIAL HISTORY:

Occupation ___________________________ Marital status: □ Married  □ Single  □ Divorced
How many children do you have? ___________________________
Have you ever smoked?  □ Yes  □ No  (□ cigarettes, □ cigar, □ pipe)
How much, and for how long have you smoked? _______ packs per day for _____ years.
How much alcohol do you drink each day? ___________________________
List any street drugs you currently use: ____________________________________________
Do you have any drug addictions?  □ Yes  □ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

□ Weight loss _______ pounds in the past _______ weeks  □ Fever, chills

EYES:

□ Double vision  □ Loss of vision  □ Eye pain

ENT:

□ Hearing loss  □ Ringing in ears  □ Dizziness  □ Ear pain  □ Ear drainage

□ Nose drainage  □ Nasal congestion  □ Facial pain  □ Headaches  □ Sore mouth/throat

□ Swallowing pain  □ Voice change  □ Snoring  □ Hoarseness  □ Poor sleep

CARDIOVASCULAR/PULMONARY:

□ Chest pain  □ Poor circulation  □ Shortness of breath

□ Heart attack  □ Leg pain during walking  □ Asthma

□ Irregular heartbeat  □ Coughing up blood

GASTROINTESTINAL:

□ Stomach ulcers  □ Blood in stool

□ Nausea/vomiting  □ Trouble swallowing

□ Diarrhea  □ Abdominal pain

GENITOURINARY:

□ Blood in urine

□ Pain during urination

□ Difficulty making urine

MUSCULOSKELETAL:

□ Neck/Spine surgery

□ Neck or Back disorder

□ Arthritis

NEUROLOGICAL:

□ Stroke  □ Loss of sensation

□ Ministroke  □ Paralysis of an arm or leg

□ Temporary loss of vision or speech control  □ Facial paralysis

SKIN:

□ Skin cancers

□ Allergy to medical tape, iodine, or latex

PSYCHIATRIC:

□ Clinical depression  □ Hallucinations

□ Schizophrenia  □ Other psychiatric disorder (list)

□ Anxiety

INFECTIOUS DISEASE:

□ Hepatitis  □ HIV/AIDS  □ Mononucleosis

I have personally reviewed this history and review of systems:

Attending Physician Signature ___________________________ Date ____________