

SOCIAL HISTORY

This information is kept strictly confidential. However you may discuss this portion directly with the Doctor if you prefer.

I would prefer to discuss my social history directly with the doctor: Yes No

Do you drive? Yes No If yes do you have any visual difficulty while driving? Yes No If yes please describe: _____

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following areas:

<u>SYSTEM</u>	<u>YES</u>	<u>NO</u>	<u>FAMILY</u>	<u>SYSTEM</u>	<u>YES</u>	<u>NO</u>	<u>FAMILY</u>
<u>CONSTITUTIONAL</u>				<u>EARS/NOSE/MOUTH/THROAT</u>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>INTEGUMENTARY (SKIN)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>NEUROLOGICAL</u>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ENDOCRINE</u>				<u>RESPIRATORY</u>			
Thyroid/Other Gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ALLERGIC/IMMUNOLOGIC</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>PSYCHIATRIC</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>GASTROINTESTINAL</u>				<u>VASCULAR/CARDIOVASCULAR</u>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>GENITOURINARY</u>				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>BONES/JOINTS/MUSCLES</u>				<u>LYMPHATIC/HEMATOLOGIC</u>			
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered YES to any of the above or have a condition not listed please explain: _____

Do you have any allergies to medication? Yes No If yes, explain: _____

Are you currently taking medication? (Include Vitamins & OTC products): _____

Any major injuries, surgeries or hospitalizations? Yes No If yes, explain: _____

Thank You for your continued business and support!

Doctor's signature (History reviewed with patient): _____ Date _____ / _____ / _____