Patient Name:_____ Date:_____
DOB:_____Marital Status: Single Divorced Married Widow(er)
Occupation:_____ Type of Work:_____
Primary Care Physician:_____Pharmacy:_____

REVIEW OF SYSTEMS: Do you have any of these problems?

System	No	Yes	System	No	Yes	System	No	Yes
Gastro			**Respiratory**			Blood Disorders		
Diarrhea			Asthma			**Skin**		
Constipation			Pneumonia			Rash		
Rectal Bleeding			Bronchitis			Bruises		
Change in BM's			Chronic Cough			**Ophthalmic**		
Weight Loss			Hoarseness			Cataracts		
Polyps			Tracheostomy			Glaucoma		
Irritable Bowel			**Genitourinary**			Blindness		
Crohn's Disease			Kidney Disease			**Ear, Nose, & Throat**		
Ulcerative Colitis			Frequent UTI's			Nosebleeds		
Trouble Swallowing			**Endocrine**			Deafness		
Nausea/Vomiting			Diabetes			**Psychosocial**		
Heartburn			Thyroid Disorders			Alcoholism		
Abdominal Pain			**Neurologic**			Substance Abuse		
Hepatic			Seizures			Depression		
Liver Disease			Weakness			Anxiety Disorders		
Hepatitis			Migraines			**Other**		
Pancreatitis			Previous Stroke			Breast Lumps		
Cardiac			**Musculoskeletal**			Gallbladder		
High Blood Pressure			Muscle Disease			Hernia		
Low Blood Pressure			Arthritis			**Cancer**		
Irregular Heartbeat			Neck Pain			Type:		
Chest Pain			Back Pain			Any other symptoms:		

ALLERGIES:

Penicillin	No	Yes	Iodine Compounds	No	Yes
Sulfa	No	Yes	Adhesive Tape	No	Yes
Aspirin	No	Yes	Latex (gloves)	No	Yes
Codeine/Morphine	No	Yes	Tetanus Antitoxin	No	Yes
Mycins/Other Antibiotics	No	Yes	Any other drug:	No	Yes

If yes please list:_____

MEDICATIONS: Please list the medications you are taking, along with the dosage and how often you take them:_____
_____
_____

SURGERY: Have you had previous surgery: No Yes please list what and when:
_____
_____

HABITS:
Do you drink coffee?_____ Tea?_____ Soft Drinks?_____ Chocolate?_____
Alcoholic Beverages (please Circle) Never Rarely Moderate Daily
Tobacco: Cigarettes_____ packs per/day Cigars____ Pipe_____ Chewing____ Snuff_____ Former_____

FAMILY HISTORY: Have any of your immediate family members ever been diagnosed with cancer? If yes, who and what type of cancer? _____
_____