



**Social History/Habits**

Employment:  Occupation \_\_\_\_\_  
 Student  Retired  Work at home  
 Status:  Single  Married  Divorced  Widowed  Partnered  
 Any children?  No  Yes  
 Do you live alone?  No  Yes  
 Exercise?  Daily  1-2x per week  3-5x per week  Rarely  Never  
 What type of exercise? \_\_\_\_\_  
 Have you used marijuana?  No  Yes  
 Have you used recreational drugs?  No  Yes  
 Have you used IV drugs?  No  Yes If yes, please list: \_\_\_\_\_  
 Have you used tobacco?  No  Yes If yes, please check:  Smoke  Smokeless  
 If yes, how much per day? \_\_\_\_\_  
 Have you quit smoking?  This year  > 1 year  >5 years  >10 years  
 Previously smoked: \_\_\_\_\_ per day for \_\_\_\_\_ years.  
 Do your drink alcohol?  No  Yes  
 If yes, how often?  Daily  1-2 x per week  1-2 x per month  1-2 x per year

**Chronic Medical Problems**

Are you currently having or have you had problems with: (Please mark "No" or "Yes" and describe all "Yes" responses.)

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Arthritis	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Osteoporosis	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Glaucoma	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sinus Infections	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tuberculosis	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ulcers/Gastritis/Reflux	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Constipation	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	High Blood Pressure	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	High Cholesterol	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart Problems	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Clots	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Problems	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Migranes	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fatigue	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blackout/Fainting	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seasonal Allergies	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Skin Problems	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Gallbladder Problems	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma/Bronchitis/Pneumonia	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Stones	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Urinary Tract Infections	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Incontinence	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	HIV/AIDS	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Psychological	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	_____

If yes: TYPE  A  B  C

**Review of Systems (continued)**

(Check all that apply and briefly describe.)

	Symptom	No	Yes	If yes, please explain.
Have you recently noticed:	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	
	Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	
	Disturbed sleep or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have:	Delayed Healing	<input type="checkbox"/>	<input type="checkbox"/>	
	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	
	Hives	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently had:	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	
	Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
	Blackouts or Falling	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
	Frequent Coughs	<input type="checkbox"/>	<input type="checkbox"/>	
	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	
	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	
	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	
	Frequent Urination at Night	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Lumps in Your Breasts	<input type="checkbox"/>	<input type="checkbox"/>	
	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain in Other Joints	<input type="checkbox"/>	<input type="checkbox"/>	
	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have...	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	
	Tingling/Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel	Anxious	<input type="checkbox"/>	<input type="checkbox"/>	
	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	
Do you...	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	
	Have Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	
	Suffer from Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have any other signs, symptoms, or problems other than listed above?  No  Yes

If yes, please explain: \_\_\_\_\_

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