PAST MEDICAL HISTORY

Previous Surgeries and Chronic Conditions

1) History of stroke? . . . . . YES NO
2) Any lung disease? *(COPD, Asthma).* . .YES NO
3) Any GI issues? *(PUD, cirrhosis)*. . . . . YES NO
4) Any blood disorders? *(Anemia)*. . . . YES NO
5) Are you on Dialysis? . . . . . YES NO
6) History of cancer? . . . . . YES NO
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____
13) _____
14) _____

SOCIAL HISTORY/ HABITS *(Circle selection)*

Marital Status: . . . . Single Married Divorced Widowed

Children: . . . . . YES NO

Caffeine Status: YES NO
Coffee Chocolate Tablets Soda Tea

Alcohol Status: Current Never Former
Year Quit: _____
Frequency: _____

Drug Use / Abuse Status: Current Never Former
Year Quit: _____
Type: _____
Frequency: _____

Primary Language: English or _____

REVIEW OF SYSTEMS

(Please check each box, if you have EVER HAD)

Cardiac	☐ Chest pain	☐ Diaphoresis (*sweating*)	☐ Orthopnea (*difficulty breathing while laying down*)
	☐ Palpitation	☐ Syncope	
Vascular	☐ Claudication (*pain in calves / thighs / buttocks when walking)*	☐ Edema (*legs and ankles swell)*	
Constitutional	☐ Weight gain	☐ Weight loss	☐ Fever
Respiratory	☐ Snoring	☐ Hemoptysis (*bloody sputum*)	☐ Dyspnea (*shortness of breath with activity)*
Neurological	☐ Dizziness	☐ Memory loss	☐ Seizures
Reproductive	☐ Erectile dysfunction		
Endocrine	☐ Goiter (*thyroid gland growth*)		