

Patient Name: _____ Age: _____ Date: _____

Present

Medications: _____

Allergies: _____

Reason for today's visit: (chief complaint) _____

Current or past problems with: (review of symptoms)

	Yes	No	If Yes, Please Explain
General Health	_____	_____	_____
Eyes	_____	_____	_____
Ears/Nose/Throat/Mouth	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Stomach/Bowel	_____	_____	_____
Kidneys	_____	_____	_____
Arthritis/Muscles/Joints	_____	_____	_____
Skin	_____	_____	_____
Headaches/Seizures	_____	_____	_____
Psychological Disorder	_____	_____	_____
Thyroid/Diabetes	_____	_____	_____
Blood/Bleeding Disorder	_____	_____	_____
Allergic/Immunologic	_____	_____	_____
HIV	_____	_____	_____
Radiation Therapy	_____	_____	_____
Skin Cancer	_____	_____	_____
Malignant Melanoma	_____	_____	_____
Dysplastic/Atypical Moles	_____	_____	_____

Females: Are you currently pregnant? ___Yes___No Planning to become pregnant? ___Yes___No

Family History: (past family and social history)

Mother: living/deceased Age_____ Father: living/deceased Age_____ No. of children___ Age(s) _____

Check following medical conditions that have occurred in your family:

	Mother	Father	Blood Relative
Allergies	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Eczema	_____	_____	_____
Hayfever	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Lung Disease	_____	_____	_____
Malignant Melanoma	_____	_____	_____
Psoriasis	_____	_____	_____
Skin Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____

Social History:

Do you live alone? ___Yes ___No
 Do you drink alcohol? ___Yes ___No
 Do you smoke? ___Yes ___No
 Do you use recreational drugs? ___Yes ___No
 Occupation: _____

Hobbies/Leisure Activities: _____

Reviewed: _____

Nancy Satur, M.D.

Stacy Tompkins, M.D.

Gary Vanetsky, M.M.S., PA-C

Berna Moore, PA-C, M.C.M.S.

Date: _____ Updated: _____

Joanne Butler, R.N., N.P.