



**Past Medical History:**

Hospitalization	Age	Year	For
Surgeries	Age	Year	For
Drug allergy	Reaction		

Are your immunizations up to date?      Yes      No

Other chronic health conditions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History:** (father, mother, sibling, grandparent)  
 [circle all that apply and indicate who had which ailment]

- |                             |                     |
|-----------------------------|---------------------|
| Asthma                      | Hives               |
| Eczema                      | Bronchitis          |
| Tuberculosis                | Hypertension        |
| Cystic fibrosis             | Liver disease       |
| Arthritis                   | Cancer              |
| Endocrine/<br>Gland disease | Frequent infections |
| Hay Fever                   | Emphysema           |
| Sinus infections            | Heart disease       |
| Diabetes                    | Infant deaths       |

**Social History:** (circle all that apply)

What environment do you currently live in?

House    Apartment    Trailer    Rural    Urban

Occupation: \_\_\_\_\_

Marital status: (circle one)    S      M      D      W

	Y	N		Y	N
Live in basement			Cigarette smoke		
Plastic covered mattress			Forced air heat		
Plastic covered pillow			A/C		
Feather pillow			Change filters		
Down bedding			Pet		
Carpet/rugs			Fan/humidifier		
House plants			Stuffed toys		
Cockroaches			Windows closed		
Type of window treatment: (circle all that apply)					
blinds		curtains		shades	

Smoke: (circle one) Y N    Quit \_\_\_\_\_ yrs ago

How many packs do you smoke per day? \_\_\_\_\_

Exercise regular: (circle one) Y N    Type \_\_\_\_\_

Lives with \_\_\_\_\_

**Review of Systems:** (check all that *apply to you*)

<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Appetite change	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Activity change	<input type="checkbox"/>	Leg cramps
<input type="checkbox"/>	Voice change	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Smell change	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	Bladder infections
<input type="checkbox"/>	Red eyes	<input type="checkbox"/>	Change in periods
<input type="checkbox"/>	Eye swelling	<input type="checkbox"/>	Itching
<input type="checkbox"/>	Eye infections	<input type="checkbox"/>	Bruising
<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	Change in sensation
<input type="checkbox"/>	Dizzy	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	Constant thirst
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Ear popping	<input type="checkbox"/>	Feel hot/cold
<input type="checkbox"/>	Throat infections	<input type="checkbox"/>	Other: _____

**Healthcare provider's note taking space.**

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