

PAST HISTORY, FAMILY HISTORY, SOCIAL HISTORY AND REVIEW OF SYSTEMS

TODAY'S DATE: ___/___/___

Patient's Name: _____ Patient's Phone: (____) _____ Cell Phone: (____) _____

Referring Physician's Name: _____ Location: _____

Primary Care Provider: _____ Location: _____

Date of Birth: ___/___/___

Main Problem(s): (Please write brief description.)

Social History: Age: _____ Height: _____ Weight: _____ kg's Handedness: Right Left

Marital Status: Married Single Widowed # of marriages _____ Divorced _____ # of Divorces

Education Level: _____ Degree: _____ Occupation Current: _____ Previous: _____

Living Situation: Alone With Spouse With Friend With Child Parents Other: _____

In-Home Care (if so, please describe.): _____

Who makes your medical decisions if you are incapable? _____ Power of Attorney: YES NO

Relationship _____

Tobacco: Current Use: YES NO Past Use: YES NO If quit, when? _____

If yes to either: Cigarettes: _____ packs/day _____ # years

Cigars: _____ # years

Pipe: _____ # years

Chewing tobacco: _____ # years

Alcohol: Current use: YES NO Past Use YES NO If quit, when? _____

If yes, to either: Type: _____ Amount: _____ # drinks/day Problems with Alcohol YES NO

Drug Use: YES NO If yes, what? _____

Current Medications:

<u>Medications</u>	<u>Strength</u>	<u># pills/day</u>	<u>Medications</u>	<u>Strength</u>	<u># pills/day</u>
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____

Medication Allergies: YES NO Medication(s): _____

Past Medical History:

Endocrine Disorders

Diabetes YES NO

Thyroid YES NO

Explain Other: _____

Vascular Surgery YES NO

Heart Attack YES NO

Heart Failure YES NO

Abnormal Rhythm YES NO

Fainting YES NO

Explain Other: _____

Cardiovascular Disorders

Blood Clots YES NO

High Blood Pressure YES NO

Atherosclerosis YES NO

Aneurysm YES NO

Lung Disorders

Asthma YES NO

COPD YES NO

Explain Other: _____

Past Medical History (cont):

Kidney Disorders YES NO

Gastrointestinal Disorders YES NO

Orthopedic (bone) Disorders YES NO

Neurologic Disorders

Multiple Sclerosis YES NO

Myasthenia Gravis YES NO

Myopathy (muscle) YES NO

Neuropathy (nerve) YES NO

Parkinson's Disease YES NO

Seizures YES NO

Stroke YES NO

Spine (disk) YES NO

Neck (cervical) YES NO

Low back (lumbar) YES NO

Explain other: _____

Rheumatologic Disorders YES NO

Rheumatoid Arthritis YES NO

Gout YES NO

Osteoarthritis YES NO

(Degenerative arthritis)

Accidents/Injuries YES NO _____

Dates of accidents: _____ Description: _____

Dates of accidents: _____ Description: _____

Were any accidents work-related? YES NO _____

Is any litigation (lawsuit) pending? YES NO _____

Family History: For living relatives, indicate age and any illnesses. For deceased relatives, indicate age at death and cause of death.

Living Relatives

Parents	Age	Illnesses
Father	_____	_____
Mother	_____	_____

Siblings: Brothers (B) & Sisters (S)

	Age	Illness
B or S	_____	_____
B or S	_____	_____
B or S	_____	_____

Children: Sons (S) & Daughters (D)

S or D	_____	_____
S or D	_____	_____
S or D	_____	_____

List any disorders known to run in the family: _____

Chronic Fatigue Synd. YES NO

Fibromyalgia YES NO

Explain Other: _____

Ophthalmologic Disorder YES NO

Cataracts YES NO

Retinopath YES NO

Visual Loss YES NO

Macular Degeneration YES NO

Explain Other: _____

Cancer YES NO

Explain Other: _____

Past Surgeries YES NO

Back Surgery YES NO

Coronary Artery Bypass YES NO

Hip Surgery YES NO

Knee Surgery YES NO

Neck Surgery YES NO

Prostate (TURP) YES NO

Cancer YES NO

Explain Other: _____

Explain Other: _____

Deceased Relatives

Age at Death	Cause of Death
_____	_____
_____	_____

Age	Illness
_____	_____
_____	_____
_____	_____

Review of Systems

Current Symptoms

Constitutional

- Weight Gain YES NO
- Weight Loss YES NO
- Fever YES NO
- Chills YES NO
- Night Sweats YES NO

Explain other: _____

Skin

- Rashes YES NO
- Other Skin Abn. YES NO

Explain other: _____

Eyes

- Dry Eyes YES NO
- Poor Vision YES NO
 - Both Eyes YES NO
 - Left Eye YES NO
 - Right Eye YES NO
- Glasses YES NO
- Contacts YES NO
- Double Vision YES NO
- Blurry Vision YES NO

Explain other: _____

Ears, Nose & Throat

- Dry Mouth YES NO
- Hearing Problem YES NO
- Ringing in Ears YES NO
- Vertigo (dizziness) YES NO
- Swallowing Problems YES NO
- Hoarseness YES NO

Explain other: _____

Lungs

- Shortness of Breath YES NO
 - When Active YES NO
 - At Rest YES NO
 - Lying Flat YES NO
- Cough YES NO
- Wheezing YES NO

Explain other: _____

Heart

- Chest Pain YES NO
- Palpitation YES NO
- Lightheadedness YES NO
- Fainting Spells YES NO

Gastrointestinal

- Loss of Appetite YES NO
- Nausea YES NO
- Vomiting YES NO
- Diarrhea YES NO
- Constipation YES NO
- Bowel Incontinence YES NO
- Blood in Stool YES NO

Explain other: _____

Genitourinary

- Bladder Control YES NO
- Frequent Urination YES NO
- Burning with Urination YES NO
- Pain with Urination YES NO
- Difficulty Starting Urine YES NO
- Blood in Urine YES NO
- Sexual Problems YES NO

Explain other: _____

Blood

- Easy Bleeding YES NO
- Easy Bruising YES NO

Explain other: _____

Endocrine

- Excessive Thirst YES NO
- Feeling Hot YES NO
- Menopause YES NO
- PMS YES NO

Explain other: _____

Musculoskeletal

- Muscle Pain YES NO
- Joint Pain YES NO
- Bone Pain YES NO
- Muscle Swelling YES NO
- Joint Swelling YES NO

Explain other: _____

Neuromuscular (Check all that apply.)

- Numbness face fingers hands arms toes feet legs abdomen back whole body
- Tingling face fingers hands arms toes feet legs abdomen back whole body
- Loss of feeling face fingers hands arms toes feet legs abdomen back whole body
- Weakness face fingers hands arms toes feet legs abdomen back whole body
- Difficulty Walking YES NO If yes, reason(s): pain fatigue poor balance weakness dizziness
- Fatigue YES NO Difficulty Swallowing YES NO Difficulty Speaking YES NO

Psychiatric

- Depression YES NO
- Anxiety YES NO
- Uncontrollable Thoughts YES NO
- Past Suicidal Thoughts YES NO
- Current Suicidal Thoughts YES NO

Explain other: _____

Sleep

- Do you have trouble sleeping at night? YES NO
- Do you snore at night? YES NO

Sleep (cont)

- Are you sleepy during the day? YES NO
- Do you have unwanted behaviors during sleep? YES NO
- Do you or your partner notice you gasping for air during sleep? YES NO
- Do you or your partner notice you holding your breath or stopping breathing during sleep? YES NO

EPWORTH SLEEPINESS SCALE: Use the following scale to choose the most appropriate number for each situation:
(0= no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing)

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (e.g. a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car stopped for a few minutes in traffic	0 1 2 3
TOTAL	

Please provide the address of the physician that you would like this note to be sent to: (i.e., Primary Care Physician).

Name: _____

Name: _____

Address: _____

Address: _____

Completed by: _____

Date: ____/____/____

Reviewed by: _____

Date: ____/____/____