NAME: **DATE:**

PERSONAL HISTORY: HAVE YOU HAD ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, EXPLAIN.

	YES	NO	EXPLANATION OF PROBLEM
SKIN	[ ]	[ ]	_____
MEDICAL/ILLNESSES	[ ]	[ ]	_____
SURGICAL/TREATMENTS	[ ]	[ ]	_____
INJURIES	[ ]	[ ]	_____
DO YOU HAVE ANY OF THE FOLLOWING?			
STENT (WITHIN PAST YEAR)	[ ]	[ ]	_____
PACEMAKER/DEFIBRILLATOR	[ ]	[ ]	_____
ARTIFICIAL VALVE/JOINTS	[ ]	[ ]	_____
HEART MURMUR	[ ]	[ ]	_____
TAKE ANTIBIOTIC BEFORE DENTIST	[ ]	[ ]	_____

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY HAD ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, EXPLAIN AND GIVE YOUR RELATIONSHIP TO THAT PERSON.

	YES	N0	EXPLANATION OF PROBLEM/RELATIONSHIP
SKIN	[ ]	[ ]	_____
MEDICAL	[ ]	[ ]	_____
HEREDITARY DISEASES	[ ]	[ ]	_____

SOCIAL HISTORY:

OCCUPATION			_____
ALCOHOL	[ ]	[ ]	
TOBACCO	[ ]	[ ]	
			IF YES, LIST
DRUG ALLERGIES:	[ ]	[ ]	_____
			_____

REVIEW OF SYSTEMS:

CONSTITUTIONAL: ESTIMATE YOUR OVERALL HEALTH: **[ ] EXCELLENT [ ] GOOD [ ] FAIR [ ] POOR**

DO YOU PRESENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, EXPLAIN

	YES	N0	EXPLANATION OF PROBLEM
EYES	[ ]	[ ]	_____
EARS, NOSE MOUTH, THROAT	[ ]	[ ]	_____
CARDIOVASCULAR (HEART, BLOOD VESSELS)	[ ]	[ ]	_____
RESPIRATORY (LUNGS/BREATHING)	[ ]	[ ]	_____
GASTROINTESTINAL (STOMACH/INTESTINE)	[ ]	[ ]	_____
GENITOURINARY (BREASTS/GENITALS/KIDNEY/BLADDER)	[ ]	[ ]	_____
MUSCULOSKELETAL (MUSCLES/JOINTS)	[ ]	[ ]	_____
INTEGUMENTARY: (SKIN, HAIR, NAILS, MUCOUS MEMBRANES)	[ ]	[ ]	_____
NEUROLOGICAL	[ ]	[ ]	_____
PSYCHIATRIC			
ENDOCRINE (HORMONES, GLANDS)	[ ]	[ ]	_____
HEMATOLOGIC/IMMUNOLOGIC (BLOOD)	[ ]	[ ]	_____
			IF YES, LIST
CURRENT MEDICATIONS:	[ ]	[ ]	_____

_____
_____
_____
_____
_____

OFFICE USE ONLY
PHYSICIAN'S INITIALS:_____