Family History

List all serious illnesses (example: diabetes, colon cancer, etc) in your **immediate family** (grandparents, parents, siblings and children – Do **NOT** include your spouse) which started at age 70 or younger.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Symptoms

Do you now have or have you recently had any of the following problems? Please circle Y or N for each problem you have experienced.

Constitutional symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight loss/gain	Y	N

Other: _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N

ENT

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Hay fever	Y	N

Other: _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other: _____

Cardiovascular

Chest pain	Y	N
Swelling of feet	Y	N
Circulatory problems	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Short of breath	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness	Y	N
Tingling	Y	N

Skin

Rash	Y	N
Boils	Y	N
Itching	Y	N

Other: _____

Hematology

Swollen glands	Y	N
Bleeding problem	Y	N
Anemia	Y	N

Other: _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other: _____

Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Weakness	Y	N

Other: _____

Psychological

Depression	Y	N
Anxiety	Y	N
Obsessions	Y	N
Hyperactivity	Y	N
Alcoholism	Y	N

Other: _____

Social History

Do you smoke?	Y	N	If yes, how many packs per day? _____	Quit _____ years ago
Do you drink alcohol?	Y	N	If yes, how many glasses per week? _____	Of what? _____
Do you use drugs?	Y	N	If yes, which ones? _____	How often? _____