MEDICAL / SOCIAL HISTORY

Patient Name _____ **Birthdate** _____ **Date** _____

PCP/PCM _____ **Referring Physician** _____

Reason for Today's Visit: _____

How long have you had this problem?_____
How severe is this problem? ☐ mild ☐ moderate ☐ very How often are you having this problem?_____
What caused the problem?_____
Do you know of anything else that may have contributed to this problem?_____
Does anything else occur with this problem?_____
Additional Comments:
_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily (How much?) _____
Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current; packs per day_____ ☐ Current, Electronic Cigarette
Use of drugs: ☐ Never ☐ Type/Frequency_____
Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

FAMILY HISTORY

	AGE	DISEASE/PROBLEM	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			
SPOUSE			
CHILDREN			

List previous hospitalizations / Surgeries / Serious Injuries	Date (Approximate Okay)

Allergies (Drug & Environmental)

MEDICATION LIST --- Preferred Pharmacy?_____

Name of Medication & Strength	☐ **SEE ATTACHED LIST** *If you have more medications than the space provides, please attach a copy of your list of medications.*

MEDICAL / SOCIAL HISTORY

Have you every had/been diagnosed with:			
☐Yes ☐No	Cancer	☐Yes ☐No	Venereal Disease
☐Yes ☐No	Arthritis/Gout	☐Yes ☐No	Hypertension
☐Yes ☐No	Acute Infections	☐Yes ☐No	Heart Trouble
☐Yes ☐No	Diabetes	☐Yes ☐No	Bleeding Tendency
☐Yes ☐No	Stroke	☐Yes ☐No	Hereditary Defects
☐Yes ☐No	Convulsion		

Please answer and explain each section, with regard to the past 6 months**.**

Have you experienced any problems/sensation within the past 6 months? ** If none/no response, please put "NONE" *

CONSITUTIONAL: *General health, fevers, fatique, weight changes…etc.*	**MUSCULOSKELETAL:** *Joint pain/stiffness or weakness, Back, difficulties...etc.*
EYES: *Discharge, pain, blurry vision, do you wear contacts/glasses?, cataracts*	**SKIN:** *Rash/itching, change in color, hair/nails, varicose veins, breast pain/lump, discharge*
ENT (Ear/Nose/Throat): *Hearing loss, ringing, nose bleeds, sores, bleeding gums, bad breath/tase, voice changes, sore throat, etc.*	**GENITOURINARY:** *Frequent urination, burning/pain, kidney stones, incontinence, female menstrual related problems, male testicle pain… etc.*
CARDIOVASCULAR: *Heart/chest problems, pain, irregular heart beats, swelling of feet/ankles/hands…etc.*	**NEUROLOGIC:** *Headaches, dizziness, tremors, paralysis, stroke, seizures, convulsions, numbness, tingling sensations… etc.*
RESPIRATORY: *Coughing, spitting blood, shortness of breath, asthma, wheezing… etc.*	**PSYCHIATRIC:** *Memory loss, nervousness, depression, anxiety, sleep problems, etc.*
GASTROINTESTINAL: *Loss of appetite, change in bowel movement, nausea, vomiting, diarrhea, pain, blood in stool, stomach pain, etc.*	**ENDOCRINE:** *Glandular or hormone problems, thyroid disease, excessive thirst or urination, heat or cold intolorence, dry skin, change in hat or glove size, etc.*
HEMATOLOGIC/LYMPHATIC: *Slow heal after cuts, easily bruises or bleeds, anemia, phlebitis, past transfusion, enlarged glans, dialysis, etc.*	

PATIENT SIGNATURE