PAST MEDICAL HISTORY (Please check all that apply):

CARDIAC:	[ ] Heart Attack	[ ] Murmur	[ ] Abnormal Rhythm	[ ] Other: _____
PULMONARY:	[ ] Asthma	[ ] COPD	[ ] Emphysema	[ ] Other: _____
ENDOCRINE:	[ ] Diabetes	[ ] Hypothyroid	[ ] Pituitary Tumor	[ ] Other: _____
CIRCULATORY:	[ ] Hypertension	[ ] Stroke	[ ] Aneurysm	[ ] Other: _____

PAST SURGICAL HISTORY (Please list type, date, surgeon/hospital):

_____ _____ _____

_____ _____ _____

MEDICATIONS (If more space is needed, please use back of form or attach list)

MEDICATION	DOSAGE	FREQUENCY	DURATION TAKEN
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES: _____

FAMILY HISTORY: (Please check and indicate which parent/sibling and year of illness/death):

CARDIAC:	[ ] Heart Attack	[ ] Hypertension		_____
PULMONARY:	[ ] Asthma	[ ] COPD	[ ] Emphysema	_____
ENDOCRINE:	[ ] Diabetes	[ ] Hypothyroid		_____
NEUROLOGIC:	[ ] Stroke	[ ] Aneurysm	[ ] Tumor	_____
CANCER:	[ ] Lung	[ ] Breast	[ ] Intestinal	_____
OTHER:	[ ] _____	[ ] _____	[ ] _____	_____

SOCIAL HISTORY:

Occupation: _____ How long? _____ Date Unemployed: _____

Substance Use (Amount/Frequency: Tobacco: _____ Alcohol: _____ Other: _____

REVIEW OF SYSTEMS (Please check all that apply):

Neurologic:	[ ] Headache	[ ] Dizziness	[ ] Memory	[ ] Numbness	Other: _____
Eyes:	[ ] Glasses	[ ] Contacts	[ ] Blurriness	[ ] Double Vision	Other: _____
Ears/Throat:	[ ] Deafness	[ ] Ringing	[ ] Swallowing	[ ] Hoarseness	Other: _____
Cardiac:	[ ] Chest Pain	[ ] Skip Beats	[ ] Rapid Beat	[ ] Edema	Other: _____
Pulmonary:	[ ] Cough	[ ] Cough Blood	[ ] Wheezing	[ ] Short Breath	Other: _____
Intestinal:	[ ] Constipation	[ ] Diarrhea	[ ] Incontinence	[ ] Bleeding	Other: _____
Urinary:	[ ] Frequency	[ ] Burning	[ ] Incontinence	[ ] Bleeding	Other: _____
Musculoskel:	[ ] Pain	[ ] Weakness	[ ] Arthritis	[ ] Cane/Walker	Other: _____
Endocrine:	[ ] Weight Gain	[ ] Weight Loss			Other: _____
Skin:	[ ] Bruising	[ ] Lesions	[ ] Birthmarks		Other: _____
Hematology:	[ ] Bleeding	[ ] Transfusion	[ ] Hepatitis		Other: _____
Psychiatric:	[ ] Depression	[ ] Insomnia	[ ] Fatiguability		Other: _____

Signature: _____ Date: _____ rev 7/2014