Name: _____ Birthdate: _____ Today's Date: _____

## MEDICATIONS

If you don't take any medications, check this box: ☐

Please list the medications (including over the counter) you take regularly and why you're taking it:

1. _____ Reason _____
2. _____ Reason _____
3. _____ Reason _____
4. _____ Reason _____
5. _____ Reason _____
6. _____ Reason _____
7. _____ Reason _____
8. _____ Reason _____
9. _____ Reason _____
10. _____ Reason _____
11. _____ Reason _____
12. _____ Reason _____

If you take a blood thinning medication, which one do you take?

Aspirin, Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Aggrenox, or other _____

## ALLERGIES

If you don't have any known drug allergies, check this box: ☐

Please list the medications that you are allergic to:

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____
4. _____ Reaction _____

Do you have a latex allergy? ☐ No ☐ Yes If yes, what's your reaction _____

Do you have an allergic reaction to adhesives/tapes? ☐ No ☐ Yes

## SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Decline to answer

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, _____ drinks per day

Use of Tobacco ☐ Never ☐ Previously, but quit: _____ ☐ Current, packs/day: _____

Use of Illicit Drugs ☐ Never ☐ Type/Frequency: _____ ☐ Decline to answer

Name: _____ Birthdate: _____ Today's Date: _____

## FAMILY MEDICAL HISTORY

Has anyone in your family had cancer ☐ No ☐ Yes

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Check (✓) if your blood relatives have ☐ Colon polyps ☐ Crohn's or ulcerative colitis ☐ Thyroid/Endocrine Problems

## REVIEWS OF SYSTEM (ROS)

Please only check the boxes only if they are bothering you TODAY

**CONSTITUTIONAL SYMPTOMS**
- ☐ Good General Health
- ☐ Recent Weight Change
- ☐ Fever/Sweats
- ☐ Fatigue
- ☐ Headache

**SKIN**
- ☐ Rashes
- ☐ Psoriasis
- ☐ Bruise Easily
- ☐ Abnormal Lumps
- ☐ *No symptoms*

**NOSE**
- ☐ Sinus Problems
- ☐ Breathing Problems
- ☐ *No symptoms*

**CARDIOVASCULAR**
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ *No symptoms*

**EARS**
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ *No symptoms*

**GENITOURINARY** ☐
Blood in Urine
- ☐ Frequency of Urination ☐
Painful Urination
- ☐ Loss of Bladder Control
- ☐ Enlarged Prostate
- ☐ *No symptoms*

**GASTROINTESTINAL**
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Loss of Bowel Control
- ☐ *No symptoms*

**ENDOCRINE**
- ☐ Excessive Thirst/Appetite
- ☐ *No symptoms*

**NEUROLOGIC**
- ☐ Headache/Migraine
- ☐ Dizziness
- ☐ *No symptoms*

**EYES**
- ☐ Visual Loss
- ☐ Double Vision
- ☐ Painful Eyes
- ☐ *No symptoms*

**THROAT**
- ☐ Sore Throat ☐ Hoarseness
- ☐ Snoring ☐
*No symptoms*

**RESPIRATORY**
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ *No symptoms*

**MUSCULOSKELETAL**
- ☐ Fractures/Sprains
- ☐ Osteoporosis
- ☐ Joint Swelling
- ☐ *No symptoms*

**OTHER** ☐ Pregnant: _____ weeks

_____
_____
_____
_____
_____

Reviewed by: _____ Date: _____

## MEDICAL ASSISTANTS USE ONLY

Ht: _____ Wt: _____ BP: _____ P: _____ T: _____