**Patient Name:** Date: Age:

Soc Sec #: Marital Status S M D W Time In_____Time Out_____

Chief Complaint

What is the main reason for your visit today? (Describe in detail)_____

_____

_____

Physician Notes

| # Answers | Level Services |
|---|---|
| 1 - 3 | 1 or 2 |
| 4+ | 3 - 5 |

**Past Medical & Social History**

List all serious illnesses in your immediate family (e.g., diabetes, heart disease, cancer, stroke):

List any prior personal illnesses
Date

_____

_____

_____

List any prior surgeries/injuries
Date

_____

_____

_____

Do you smoke: Y N

If yes, how much? _____

_____

_____

Are you on any medications? Y N

If yes, list all _____

_____

_____

Allergies_____

Physician Notes

Any change since last visit?

| # Answers | Level Services |
|---|---|
| 1 - 3 | 1 or 2 |
| 4+ | 3 - 5 |

**Review of Systems**: Any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in space provided:

Constitutional Symptoms

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Weight Loss/Gain | Y | N |
| Other _____ | | |

Eyes

| | | |
|---|---|---|
| Blindness | Y | N |
| Blurred vision | Y | N |
| Double vision | Y | N |
| Other _____ | | |

Ear/Nose/Throat/Mouth

| | | |
|---|---|---|
| Ear infection | Y | N |
| Hearing loss | Y | N |
| Ringing in ears | Y | N |
| Sinus problem | Y | N |
| Other _____ | | |

Cardiovascular

| | | |
|---|---|---|
| Heart attack | Y | N |
| Chest pain | Y | N |
| Shortness of breath | Y | N |
| High blood pressure | Y | N |
| Edema/swelling | Y | N |
| Arrhythmia | Y | N |
| Other _____ | | |

Respiratory

| | | |
|---|---|---|
| Wheezing | Y | N |
| Coughing, frequent | Y | N |
| Coughing, blood | Y | N |
| Tuberculosis | Y | N |
| Other _____ | | |

Endocrine

| | | |
|---|---|---|
| Diabetes | Y | N |
| Insulin | Y | N |
| Thyroid problem | Y | N |
| Other _____ | | |

Psychologic

| | | |
|---|---|---|
| Depression | Y | N |
| Anxiety | Y | N |
| Under psych care | Y | N |
| Other _____ | | |

Gastrointestinal

| | | |
|---|---|---|
| Abdominal Pain | Y | N |
| Vomiting Blood | Y | N |
| Blood in Stool | Y | N |
| Nausea/Vomiting | Y | N |
| Yellow Jaundice | Y | N |
| Other _____ | | |

Genitourinary

| | | |
|---|---|---|
| Urine retention | Y | N |
| Painful urination | Y | N |
| Urinary frequency | Y | N |
| Blood in urine | Y | N |
| Other _____ | | |

Musculoskeletal

| | | |
|---|---|---|
| Joint pain | Y | N |
| Back pain | Y | N |
| Neck pain | Y | N |
| Arthritis | Y | N |
| Other _____ | | |

Dermatologic

| | | |
|---|---|---|
| Skin rash | Y | N |
| Skin ulcer | Y | N |
| Difficulty with nails | Y | N |
| Other _____ | | |

Neurologic

| | | |
|---|---|---|
| Stroke | Y | N |
| Balance problem | Y | N |
| Numbness/tingling | Y | N |
| Tremors | Y | N |
| Speech difficulty | Y | N |
| Seizures | Y | N |
| Other _____ | | |

Hematologic

| | | |
|---|---|---|
| Blood clotting problem | Y | N |
| Anemia | Y | N |
| Easy bruisability | Y | N |
| Blood thinning meds | Y | N |
| Swollen glands | Y | N |
| Other _____ | | |

Miscellaneous

| | | |
|---|---|---|
| Thrombophlebitis | Y | N |
| Cancer | Y | N |
| Blood clot to lung | Y | N |
| AIDS | Y | N |

Other pertinent data not covered by the above that you feel we should know: _____

_____

Physician Notes

Any changes since last visit? Y N

| # Answers | Level Services |
|---|---|
| 1 - 3 | 1 or 2 |
| 4+ | 3 - 5 |