Social History

Marital Status:________________ Children: Yes No How many?________ Health Status______________

Occupation: ____

Smoker: Yes No Pack per day________ How many years________ When did you stop?______________

Smoke exposure in home? Yes No

Alcohol: Yes No How many per day___________ per week___________ When did you stop?_________

Coffee: Yes No ______ cups per day Tea: Yes No______ cups per day Soda: Yes No ______ Cups per day

Gum: Yes No __________ sticks per day Pets: Yes No Dog Cat Other:____________

REVIEW OF SYSTEMS (please circle any symptoms below which you experience routinely or recently or circle none

General:	Weight loss / fever / anorexia / malaise / pain / redness / discharge / fatigue	None
Eyes:	Vision loss / glasses / glaucoma / cataracts / dry eyes / tearing	None
Cardiac:	Chest pain / palpitations / edema / syncope	None
Lungs:	Shortness of breath / cough / wheezing / sputum / coughing blood	None
GI	Heartburn / reflux / constipation / diarrhea / vomiting	None
Urinary system:	Discharge / Dysuria / frequency / hematuria	None
Muscles:	Pain / swelling / deformity / joint problems / arthritis	None
Skin:	Rash / cellulites / Lesions / masses / skin cancer	None
Neurologic:	Headache / numbness / tingling / impaired gait / memory loss / speech problems	None
Endocrine:	Hot / cold intolerance / excessive thirst / unsusaul hair growth or loss	None
Psychiatric:	Depression / substance abuse / anxiety / altered moods	None
Hematologic: Lymphatic	Anemia / easy bruising or bleeding / clotting problems / swollen lymph nodes	None
Allergic/Imm:	SLE / RA / AIDS / Hives / Lyme disease / fibromyalgia	None

Chart #:________________________

Date of Visit:______/______/________ Patient Name____