

Advance Directive	<input type="checkbox"/> None	<input type="checkbox"/> Living Will	<input type="checkbox"/> Surrogate
Alcohol	<input type="checkbox"/> None		
	<input type="checkbox"/> Beer (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Wine (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Liquor (drinks/wk) : _____	Duration: _____ years	Date Discontinued: _____
Tobacco	<input type="checkbox"/> None		
	<input type="checkbox"/> Cigarette (pks/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Cigar (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Pipe (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Chew (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Snuff (#/day): _____	Duration: _____ years	Date Discontinued: _____
Drugs	<input type="checkbox"/> None		
	<input type="checkbox"/> Marijuana (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Cocaine (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Other (#/day): _____	Duration: _____ years	Date Discontinued: _____

FAMILY HEALTH HISTORY

No History of Familial Disease

Relative (i.e., Father, Mother, Uncle, Sister, etc.)	Illness (i.e., Diabetes, Heart Disease, Prostate Cancer, etc.)

REVIEW OF SYSTEMS (Check all that apply)

General	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Fever	<input type="checkbox"/> Malaise	<input type="checkbox"/> Sweats
	<input type="checkbox"/> Weight Loss		
Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain
	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Eye Irritation
Ears, Nose, and Throat	<input type="checkbox"/> Decreased Hearing	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Ear Pain
	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Pain with Swallowing	<input type="checkbox"/> Nose Bleeds
Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Peripheral Edema	
	<input type="checkbox"/> Palpitations		
Respiratory	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Sputum
	<input type="checkbox"/> Shortness of Breath		
Gastrointestinal	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tarry Stools
	<input type="checkbox"/> Bloody Stools		
Genitourinary	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Sexual Dysfunction
	<input type="checkbox"/> Difficulty Voiding	<input type="checkbox"/> Urinary Incontinence	

Musculoskeletal	<input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling
Skin	<input type="checkbox"/> Dryness <input type="checkbox"/> Suspicious Lesion	<input type="checkbox"/> Itching	<input type="checkbox"/> Rash
Neurological	<input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures	<input type="checkbox"/> Weakness	<input type="checkbox"/> Tremors
Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory Loss
Endocrine	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Weight Change	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Increased Thirst
Hematologic and Lymphatic	<input type="checkbox"/> Abnormal Bruising	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Enlarged Lymph Nodes
Allergic and Immunologic	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Itching	<input type="checkbox"/> HIV Exposure

CERTIFICATION

The above information is true to the best of my knowledge.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature