Patient Name:	MR#:
Appointment Date:	
Chief Complaint: (Please write reason, symptoms, condition or diagnosis that prompts your appointment)	

Past Medical History

EAR, NOSE AND THROAT	YES	NO	Yes - Details
Hearing difficulty	☐	☐	
Cold sores (herpes infection)	☐	☐	
RESPIRATORY	YES	NO	Yes - Details
History of tuberculosis or positive PPD	☐	☐	
CARDIOVASCULAR	YES	NO	Yes - Details
Pacemaker / defibrillator	☐	☐	
Heart murmur	☐	☐	
Artificial heart valve	☐	☐	
High blood pressure	☐	☐	
GASTROINTESTINAL	YES	NO	Yes - Details
Liver disease	☐	☐	
Diabetes	☐	☐	
Hepatitis	☐	☐	
GENITOURINARY	YES	NO	Yes - Details
Kidney disease	☐	☐	
MUSCULOSKELETAL	YES	NO	Yes - Details
Artificial joint(s). If Yes, what year?	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS	YES	NO	Yes - Details
AIDS/HIV infection	☐	☐	
Autoimmune disease	☐	☐	
Prior Staph or MRSA infection	☐	☐	
Organ transplant recipient / immunosuppression	☐	☐	
Previous radiation therapy	☐	☐	
History of any cancer	☐	☐	
OTHER: _____			
PERSONAL SKIN HISTORY	YES	NO	Yes - Details
Melanoma	☐	☐	
Non-melanoma skin cancer (i.e. Basal cell or squamous cell carcinoma)	☐	☐	
Tanning bed use	☐	☐	
Blistering sunburns	☐	☐	
Abnormal moles	☐	☐	

Patient Name:	MR#:
Appointment Date:	

FAMILY SKIN HISTORY	YES	NO	Title Family Member (Mother, Father, Grandmother, Grandfather, Brother, Sister, etc)
Are you adopted?	☐	☐	
Acne	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Melanoma	☐	☐	
Non-melanoma skin cancer	☐	☐	
Abnormal moles	☐	☐	
SOCIAL HISTORY	YES	NO	
Do you use alcohol?	☐	☐	
If yes, Do you drink socially?	☐	☐	
Do you drink daily?	☐	☐	
Smoking Status			
Never Smoked ☐ (If never smoked, proceed to Flu shot question.)			
Former Smoker	☐	☐	
Every Day Smoker	☐	☐	
Social Smoker	☐	☐	
Smoker, current status unknown	☐	☐	
Unknown if ever smoked	☐	☐	
Amount:			
> pack a day	☐	☐	
< a pack a day	☐	☐	
Started Date			
Ended Date			
Have you had the flu shot within the last year?	☐	☐	
Where?			
Are you allergic to flu shot?	☐	☐	
Are you allergic to eggs?	☐	☐	

Patient Name:	MR#:
Appointment Date:	

MEDICATIONS – Are you currently taking any medications? ☐ Yes ☐ No **If yes, please complete section below.	
Medication name	Dosage

Are you allergic to any medications? ☐ Yes ☐ No ** If yes, please complete section below.	
Medication name	Reaction

Review of Systems

Are you currently experiencing any of the following symptoms?

CONSTITUTIONAL	YES	NO	Yes - Details
Fevers / chills	☐	☐	
Night sweats	☐	☐	
Weight loss or gain	☐	☐	
SKIN	YES	NO	Yes - Details
New or changing moles	☐	☐	
Rash	☐	☐	
EYES	YES	NO	Yes - Details
Vision changes	☐	☐	
Irritation	☐	☐	
EAR, NOSE AND THROAT	YES	NO	Yes - Details
Bloody nose	☐	☐	
Mouth ulcers or gum disease	☐	☐	

Patient Name:			MR#:
Appointment Date:			
RESPIRATORY	YES	NO	Yes - Details
Shortness of breath	☐	☐	
Cough	☐	☐	
Wheezing	☐	☐	
CARDIOVASCULAR	YES	NO	Yes - Details
Chest pain	☐	☐	
Leg swelling	☐	☐	
GASTROINTESTINAL	YES	NO	Yes - Details
Abdominal pain	☐	☐	
Nausea/vomiting	☐	☐	
Diarrhea	☐	☐	
MUSCULOSKELETAL	YES	NO	Yes - Details
Muscle aches	☐	☐	
Pain in joints / arthritis	☐	☐	
LYMPHATIC / HEMATOLOGIC	YES	NO	Yes - Details
Enlarged lymph nodes	☐	☐	
Excessive bleeding or clotting problem	☐	☐	
NEUROLOGIC	YES	NO	Yes - Details
Headache	☐	☐	
Weakness	☐	☐	
Dizziness	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS	YES	NO	Yes - Details
Hay fever symptoms	☐	☐	
PSYCHIATRIC	YES	NO	Yes - Details
Anxiety	☐	☐	
Depression	☐	☐	
FEMALES	YES	NO	Yes - Details
Are you pregnant? If yes, due date_____?	☐	☐	
Trying to become pregnant?	☐	☐	
Breast-feeding?	☐	☐	
Abnormal periods?	☐	☐	

Thank you for completing your Past Medical History and Review of System forms. These will be included in your medical record.