Annual Medical and Social History Intake

Name: _____ Age:_____ Date:_____

Chief Complaint: Please describe briefly in your own words what concerns you.

_____

_____

_____

Medical History:

Do you have any of the following?

Coronary Artery Disease	Yes/No	Diabetes Mellitus	Yes/No
Chronic Renal Insufficiency	Yes/No	Elevated Cholesterol	Yes/No
Peripheral Vascular Disease	Yes/No	Hypertension	Yes/No
Ulcer Condition	Yes/No	Asthma or COPD	Yes/No
Stroke	Yes/No	Sleep Apnea	Yes/No

Please list any medical conditions not noted above:

_____

Please list any medications you are currently taking (including over the counter medications), as well as the dose and frequency:

_____

_____

_____

Please list all known allergies:

_____

Please list all prior surgeries and the year performed:

_____

Please list all hospitalizations, condition for which you were admitted, and year:

_____

Social History: (Circle One) Changed since last completed No change since last completed

Do you or did you smoke? Yes No How many packs per day? _____ How many years? _____

When did you quit smoking (if applicable)? _____

Do you drink alcohol? Yes No How many drinks per week/month?_____

Do you use any recreational drugs? Yes No Which drug(s), how often?_____ _____

Marital Status: Single Married Divorced Other:_____ _____

Children: Yes No How many? ____ Ages/sex (ex. 26 Female): _____

Birth Place (City, State, Country): _____

Highest Education Achieved: _____ College Attended: _____

Occupation: _____Employer: _____

Family History (Circle One) Changed since last completed No chance since last completed

Siblings: Yes No How many? ____ Ages/sex (ex. 46 Male): _____

Is there any family history of cancers? Yes No What type of cancer(s)? _____

Family Member	Father	Mother	Brothers	Sisters
Is the member alive or deceased?				
Current age or age at death?				
Any current health issues/ cause of death?				

Review of Systems: Do you currently have any of the following? Circle all that apply; Circle here if none

General:	Fever Fatigue Difficulty Sleeping	**Respiratory:**	Recurrent Cough Shortness of Breath	**Musculo-skeletal:**	Back Pain Joint Pain Muscle Aches
HENT:	Headaches Dizziness Visual Disturbances	**Dermatologic:**	Changes in moles Rashes Hair Loss	**Endocrine:**	Heat/Cold Intolerance Increased Thirst Change in Hair Pattern
Neck:	Pain Stiffness Swollen Glands	**Gastrointestinal:**	Abdominal Pain/Cramps Nausea Vomiting Diarrhea Constipation Bloody Stools	**Hematologic:**	Easy Bruising Abnormal Bleeding
Cardio-vascular:	Chest Pain Palpitations High Blood Pressure	**Genitourinary:**	Frequent/ Painful/ Nighttime Urination Impotence	**Neurologic:**	Seizures Nervousness Sad/ Depressed Mood

Other Symptoms not mentioned:

_____

_____

_____

_____

I attest that the above information is accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____