Reson for Visit:	Patient Name:							DOB:	Н	lt.:			Wt.:		
V N   N   Caracts   V N   N   Cancer   V N   N   Cancer   V N   Heart Altack   Heart Murmur	Reason for Visit:								Date Sympton						
Stroke or TIA Hear Attack Hear	PAST MEDICAL HISTORY														
Stroke of TIA		γ	N				Υ	N		γ	N			Тү	N
Heart Marting   Heart Misser   Type:   Kidney Disease   Other Medical History:	Stroke or TIA			Catara	acts				Depression	1		Canc	er	1	Ť
Heart Murrour   Type:   Kidney Disease   Other Medical History: High Blood Pressure   Epilepsy   Kidney Stones   Other Medical History: High Blood Pressure   Epilepsy   Kidney Stones   Other Medical History: High Blood Clots   Parkinson's   Other Medical History: High Blood Pressure   Other Medical History: History: High Blood Pressure   Other Medical History: History: High Blood Pressure   Other Medical History: High Blood Pressure   Other History: High Blood Pres														+	1
High Blood Pressure	Heart Murmur			<u> </u>										v:	
District   Parkinson's   Disbetes   Disbet	High Blood Pressure														
Asthma   Asthma   COPD   Date   Surgery/Hospitalization   Date				- ' ' '											
AST SURGICAL HISTORY  Surgery/Hospitalization    Date   Surgery/Hospitalization   Date	Bleeding Tendencies			+				Emphysema							
PAST SURGICAL HISTORY  Surgery/Hospitalization    Date   Surgery/Hospitalization   Date	HIV			· ·					Asthma						
Date   Surgery/Hospitalization   Date   Surgery/Hospitalization   Date	Glaucoma			Anemia				COPD							
Notate additional surgeries on back   Social History   Years   Quit:   Years   No   When?	PAST SURGICAL HISTORY														
Memory   Secretarian   Memory   Secretarian   Memory					Date				Surgery/Hospitalization			D	ate		
Memory   Secretarian   Secretarian   Secretarian   Memory   Secretarian	_														
SOCIAL HISTORY   No   Packs per Day:															
Memory   Secretarian   Memory   Secretarian   Memory											Votat	e addit	ional surgeries	on ba	ack -
REVIEW OF SYSTEMS: Do you CURRENTLY have any problems related to the following systems?  GENITOURINARY Y N CARDIOVASCULAR Y N RESPIRATORY Y N MEMOLOGICAL Cont'd Y Change in stream Chest pain/pressure Wheezing Memory loss Frequency > 8x per day Irregular heartbeat Frequent cough HEMATOLOGY Swollen glands Flank pain GASTROINTESTINAL MUSCULOSKELETAL Blood clore Flank pain MusculoskeLETAL Blood clore GASTROINTESTINAL MUSCULOSKELETAL Blood clore GENERAL Indigestion/heartburn Joint pain/swelling Excessive thirst Muscle weakness Tired a lot GENERAL Indigestion/heartburn Joint pain/swelling Excessive thirst Meight loss Constipation Neurological Tremors Muscle Weight loss Diarrhea Numbness/tingling OTHER  Fever PSYCHIATRIC Tremors Might sweats Depression Dizziness Maxiety Seizures  ACCINATIONS AND TESTING Date of last flu vaccination: N/A Date of last pneumococcal vaccination: N/A Date of last colonoscopy and/or sigmoidoscopy: N/A Date of last flu vaccination: N/A Date of last pneumococcal vaccination: N/A Date of last colonoscopy and/or sigmoidoscopy: N/A Date of last colonoscopy and/or sigmoidoscopy: N/A Date of last flu vaccination: N/A Date of last colonoscopy and/or sigmoidoscopy: N/A Date of last colonoscopy and/o	Smoker? ☐ Yes ☐ No Alcohol use? ☐ Yes ☐ Caffeine? ☐ Yes	No □ N	Type o T	(s): ype(s): _					Drir Hov	nks per w mucl	week n per	። day?			
GENIITOURINARY Y N CARDIOVASCULAR Y N RESPIRATORY Y N NEUROLOGICAL Cont'd Y Change in stream	PEVIEW OF SYSTEMS: Do y	ou Cl	IDDE	MTIV hav	ve any prob	lems rel	ato		the following systems?						
Frequency > 8x per day									Υ	N	NEUR	OLOGICAL Cont'd	Υ	N	
Blood in urine	Change in stream			-				Wheezing			Memory loss			1	
Flank pain	Frequency > 8x per day			<u>' ''</u>				Frequent cough			HEMATOLOGY			1	
Pain with urination	Blood in urine			Ankle swelling				Shortness of breath			Swollen glands			1	
Change in sex drive?  Nausea/vomiting  Muscle weakness  Tired a lot  GENERAL  Indigestion/heartburn  Weight loss  Constipation  Chills  Diarrhea  Numbness/tingling  OTHER  Fever  PSYCHIATRIC  Night sweats  Depression  Depression  Dizziness  Anxiety  Seizures   ACCINATIONS AND TESTING  Date of last pneumococcal vaccination:  Do you require antibiotics prior to dental procedures?  YAMILY HISTORY (Parent, sibling, or child)  FAMILY HISTORY (Parent, sibling, or child)  Prostate cancer  Kidney stones  Heart disease  Kidney Stones  Kidney Stones  Tired a lot  Dix leveakness  Tired a lot  Excessive thirst  Too hot/cold  Too hot/col	Flank pain			GASTROINTESTINAL				MUSCULOSKELETAL			Blood clots				
Change in sex drive?  Nausea/vomiting  Muscle weakness  Tired a lot  GENERAL  Indigestion/heartburn  Weight loss  Constipation  NEUROLOGICAL  Too hot/cold  Too hot/cold  OTHER  Fever  PSYCHIATRIC  Tremors  Night sweats  Depression  Depression  Dizziness  Anxiety  Seizures   ACCINATIONS AND TESTING  Date of last pneumococcal vaccination:  Do you require antibiotics prior to dental procedures?  YAMILY HISTORY (Parent, sibling, or child)  Prostate cancer  Kidney stones  Heart disease  Nausea/vomiting  Muscle weakness  Tired a lot  Excessive thirst  Too hot/cold  OTHER  Too hot/cold  OTHER  Too hot/cold  Too hot/cold  Too hot/cold  OTHER  Too hot/cold  Too hot/cold  OTHER  OTHER  Too hot/cold  OTH	Pain with urination	+	-	Abdominal pain		+	+	Back pain			ENDOCRINE		+	+	
Indigestion/heartburn   Joint pain/swelling   Excessive thirst						T		<u>'</u>					$\top$	$\top$	
Constipation   NEUROLOGICAL   Too hot/cold														+	
Chills   Diarrhea   Numbness/tingling   OTHER  Fever   PSYCHIATRIC   Tremors   Dizziness   Depression   Dizziness   Dizziness								<u> </u>						$\top$	
Night sweats Depression Dizziness Seizures  Anxiety Seizures  Anxiety Seizures  Accinations and Testing  Date of last flu vaccination: N/A Date of last flu vaccination: N/A  Date of last colonoscopy and/or sigmoidoscopy: N/A  Date of last flu vaccination: N/A	•			Diarrhea											
Anxiety Seizures  /ACCINATIONS AND TESTING  Date of last pneumococcal vaccination: N/A Date of last flu vaccination: N/A  Date of last colonoscopy and/or sigmoidoscopy: N/A  Have you EVER had a problem with anesthesia? Yes No Explain:  Do you require antibiotics prior to dental procedures? Yes No  EAMILY HISTORY (Parent, sibling, or child)  The prostate cancer N/A Date of last flu vaccination: N/A  Explain:	Fever			PSY	/CHIATRIC				Tremors						
ACCINATIONS AND TESTING Date of last pneumococcal vaccination: N/A Date of last flu vaccination: N/A Date of last colonoscopy and/or sigmoidoscopy: N/A Have you EVER had a problem with anesthesia? Yes No Explain:	Night sweats			Depression					Dizziness						
Date of last pneumococcal vaccination:				Anx	kiety				Seizures						
Y     N     FAMILY MEMBER     Y     N     FAMILY MEMBER       Diabetes     Prostate cancer     Image: Control of the property of the pro	Date of last pneumococcal Date of last colonoscopy ar Have you EVER had a probl Do you require antibiotics p	vaccir id/or s em wi orior t	sigmo ith an o der	oidoscop esthesia otal proc	y: a?   Yes	□ No	Exp	olain:	□ N/A				□ N/.	Α	
Diabetes Prostate cancer Stidney stones Bladder cancer Heart disease Kidney Stones	AIVIILY HISTORY (Parent, S	gniiai	, or c		FAMILY M	FMRFR						N	FAMILY MEMR	FR	—
Kidney stones Bladder cancer Heart disease Kidney Stones	Diahetes	Diabetes		, 14	. AMILI MEMBER				Prostate cancer		+	14	LOWIEL MILIVID		
Heart disease Kidney Stones					<del> </del>							-			
, , , , , , , , , , , , , , , , , , ,	·														
FIGURIAN DIRECTOR	High blood pressure		$\dashv$	_					Other		-	-			