Today's Date: _____

Patient Name: _____ **DOB:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Major Surgeries: _____

_____

Allergies: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Medical Condition *(Circle All That Apply)* If **Other**, please provide as much detail as possible	**M - Mother** **F - Father** **GP - Grandparent** **S - Sibling** **P - Patient**	**Details / Explanation**
Eyes: Injury, Retinal Detachment, Glaucoma, Cataract, Macular Degeneration or Hole, Laser, Injections, Blurry Vision, Double Vision, Loss of Side Vision, Flashes and/or Floaters, Distortion, Wavy Lines, Dryness, Tearing, Itching, Redness, Pain, Halos, Other		
General / Constitutional: Fever, Weight Gain/Loss, Fatigue, Other		
Ear, Nose & Throat: Sinusitis, Hearing Aid, Chronic Cough, Dry Mouth, Other		
Cardiovascular: Heart, High Blood Pressure, Vessels, Heart Attack, Stroke, TIA, Other		
Respiratory: COPD, Emphysema, Asthma, TB, Other		
Gastrointestinal: GERD, Ulcers, Colitis, IBS, Acid Reflux, Other		
Genital, Kidney & Bladder: Enlarged Prostate, Incontinence, Renal Failure, Other		
Muscle & Skeletal: Gout, Arthritis, Joint Pain, Osteoporosis, Other		
Skin & Integumentary: Skin Cancer, Acne, Warts, Psoriasis, Other		
Neurological: Multiple Sclerosis, Parkinson's, Alzheimer's, Dementia, Stroke, TIA, Other		
Endocrine: Diabetes/Sugar, Thyroid		
Blood & lymph: Cholesterol, Anemia, Hemophilia, Sickle Cell, Other		
Psychiatric: Anxiety, Depression, Insomnia, Other		
Allergic & Immunologic: Allergies, Lupus, Sjorgen's, Other		
Hepatitis C, HIV, AIDS		
Cancer - Type & Location		
Have you ever received a blood transfusion?	**Y** or **N**	

Today's Date: _____

SOCIAL HISTORY

Patient Name: _____ **DOB:** _____

Current Occupation: _____

Education: High School College Degree Vocational School Other

Marital Status: **S**ingle **M**arried **D**ivorced **W**idowed **Do you have a living will?** **Y** or N

Student: **Y** or **N** **Retired:** **Y** or **N** **Do you currently drive?** **Y** or **N**
(Full Time / Part Time)

Tobacco Use (circle one)**:** **Never** **Current** **Former** **Quit Date:** _____
Type: _____

Alcohol Use: **Y** or **N**
Frequency: _____

Last Flu Shot: _____ **Last Pneumonia Vaccine:** _____

Do you have any special living arrangements? Assisted Living Wheelchair Walker Other

Please list any other Personal and/or Family Medical History and/or Social History you would like our physician(s) to be aware of when treating your condition: _____

----------FOR OFFICE USE ONLY----------

Updated By:	Date:	Updated By:	Date:	Updated By:	Date: