

Name _____ Date of Birth _____ Date _____

Hospitalization- list any hospitalizations and reason _____

Family History

Problem	yes	no	Relationship/Family Members	Age of diagnosis
Breast Cancer				
Ovarian Cancer				
Uterine Cancer				
Cervical Cancer				
Cardiovascular disease				
Diabetes				
Hypertension				
Kidney disease				
Thyroid disease				
Other:				

Social History

1. Do you currently consume alcohol? If so, how many drinks per week? _____
2. Do you consume caffeinated beverages? _____ If so, how much? _____ Chocolate? _____
3. Do you currently smoke? _____ if so, please indicate amount/duration in years _____; if not, did you previously smoke? _____ if so, how much/how long? _____
4. Do you use recreational drugs, anabolic steroids or other drug/supplement not otherwise listed? _____ if so, please describe _____

Review of Systems- for any "yes" answers below, please provide a description/further explanation below

Symptom	Yes	No	Symptom	Yes	No
Weight loss			Bruising easily		
Weight gain			Excessive bleeding/bleeding problem		
Fever			Swollen glands		
Fatigue			Swelling of the arms or legs/edema		
Weakness			Calf pain		
Heat intolerance			Irregular heart beat		
Cold intolerance			Chest pain/pressure		
Excessive thirst			Pacemaker or defibrillator		
Excessive urination			Nausea		
Headache			Vomiting		
Seizure			Heartburn		
Fainting, "passing out"			Constipation		
Stroke (history)			Diarrhea		
Memory loss			Abdominal pain		
Numbness or tingling			Joint pain or swelling		
Dizziness			Bone pain		
Cataracts			Back pain or problem		
Glaucoma/intraocular hypertension			Depressed/sad		