

COMMON PROBLEMS or PERSISTENT CONDITIONS (circle positives)

<u>Constitutional:</u>	weight loss/gain	night sweats	difficulty sleeping		
<u>Eyes, ears:</u>	vision change	blurriness	trouble hearing		
<u>Nose, mouth, throat:</u>	nasal congestion	problems swallowing	mouth sores		
<u>Cardiovascular:</u>	chest pain	palpatations	light headed		
<u>Respiratory:</u>	cough	wheeze	wake at night short of breath		
<u>GI:</u>	diarrhea	constipation	blood in stool	heartburn	incontinence
<u>GU:</u>		painful urination	trouble start/stop stream	night-time urination	incontinence
<u>Musculoskeletal:</u>	leg swelling	muscle pain	joint pain		
<u>Skin, breast:</u>	rash	masses	abnormal mammogram		
<u>Neuro:</u>	numbness	weakness	tremor		
<u>Psych:</u>	depression	tearfulness	anxiety	mania	
<u>Endocrine:</u>	temperature intolerance				
<u>Heme/lymph:</u>	easy bleeding	anemia			
<u>Allergies:</u>	pollens	chemicals	animals		

SOCIAL HISTORY

Single Married Separated

Children (with age) _____

Current/previous occupation: _____

Do you smoke? Yes / No If yes, how much? _____

Do you drink alcohol? Yes / No If yes, how much? _____

Did/do you use illegal drugs? Yes / No

Who lives with you? _____

Do you feel safe at home? Yes / No

FAMILY HISTORY

Mother: alive/deceased age: _____ Illness: _____

Father: alive/deceased age: _____ Illness: _____

Brother: alive/deceased age: _____ Illness: _____

Sister: alive/deceased age: _____ Illness: _____

Othe family members: _____