Please provide us with the following information so we can better care for you.
Please fill in the following information as completely as possible.

List medications and reasons for taking them. (List non-prescription medicines also)
(List medication or latex allergies or intolerances. (List reaction and side effect of each medication)

<table>
<thead>
<tr>
<th>Medications with Dose</th>
<th>Reasons for Taking It</th>
<th>Types of Medication</th>
<th>Reactions/Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Hospitalizations (Illnesses or Operations):

Immunizations
Tetanus booster: ____________________________
Flu vaccine: ____________________________
Pneumonia vaccine: ____________________________

Estimated date

<table>
<thead>
<tr>
<th></th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>g</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu vaccine:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia vaccine:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Habits - Any problems with:

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Alcohol</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

Packs per day: ____________________________
Drinks per day: ____________________________

Method(s): ____________________________
Days per week: ____________________________

Healthy diet: Y [ ] N [ ]

For Women Only

Number of pregnancies: ____________________________
Birth control method: ____________________________

Are you menopausal? Y [ ] N [ ]

Social History:
Married? Y [ ] N [ ]
Children? N [ ] Y [ ]
How many?: ____________________________

Occupation: ____________________________
Occupation of spouse/partner: ____________________________

Pets: ____________________________

List health concerns:

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
ADULT REVIEW OF SYSTEM QUESTIONNAIRE

Instructions: Please circle the symptoms below that you feel are affecting your health.

General: Weight gain, weight loss, generalized weakness, fatigue, chills, sweats, fevers, anxiety, depression, difficulty sleeping.

Eyes: Visual problems, pain, itchy eyes.

Ears: Hearing difficulty, ringing of ears, pain.

Nose: Frequent bloody nose, sinus problems, allergies, excessive snoring.

Mouth/Throat: Dental problems, ulcers, hoarseness, frequent sore throats.

Heart: Chest pains or pressure, palpitations.

Lungs: Cough, shortness of breath, wheezing, sputum production.

Gastrointestinal: Appetite changes, swallowing problems, abdominal pain, nausea, vomiting, diarrhea, heartburn, food intolerances, blood in the stool, change in stool shape or color, constipation, yellowing of the skin.

Urinary Tract: Pain with urination, difficulty urinating, dark urine, foul-smelling urine, unexpected loss of urine.

Musculoskeletal: Joint aches, joint swelling, muscular pain, back pain.

Skin: Changing freckles, rash, easy bruising, new skin lesions, nail or hair problems.

Reproduction for Females: Menstrual problems or pain, pelvic pain, hot flashes, menopause, vaginal discharge, sexual problems.

Breasts: Pain, swelling, lumps, nipple discharge.

Reproduction for Males: Testicular pain, masses, penile discharge, sexual problems, Irritations, unprotected intercourse

Neurodevelopmental: Headaches, dizziness, coordination problems, memory problems, numbness, weakness fainting, tingling, or weakness of any arm or leg.

Social: Excessive alcohol/drug use, tobacco use, have you been hit/insulted/threatened/ slapped by anyone?

Date ____________________________  Patient Signature ____________________________