

Name: \_\_\_\_\_

**Social History:** Marital status: \_\_\_\_\_ Number of children \_\_\_\_\_ International travel? \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you do heavy lifting on a daily basis? \_\_\_\_\_

Cigarette Smoking: I have smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years. Quit smoking in \_\_\_\_\_ Drug use? \_\_\_\_\_

Please describe your alcohol intake: \_\_\_\_\_ None \_\_\_\_\_ Occasional 1-2 drinks per day \_\_\_\_\_ >2 drinks per day

**Family History:** (check the box if you have immediate family members with the following conditions:)

Breast Ca \_\_\_\_\_ Ovarian Ca \_\_\_\_\_ Colon Ca \_\_\_\_\_ Skin Ca \_\_\_\_\_ Lymphoma \_\_\_\_\_ Leukemia \_\_\_\_\_

Inflammatory bowel disease \_\_\_\_\_ Brain tumors \_\_\_\_\_ Heart disease \_\_\_\_\_ Thyroid disease \_\_\_\_\_

Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Parathyroid disease \_\_\_\_\_ Other \_\_\_\_\_

**Review of Systems:** (Check the appropriate box if you have had these symptoms recently)

- |                                      |   |
|--------------------------------------|---|
| _____ Fevers                         | _____ Upper Abdominal Pain <b>Left or Right</b> _____ |
| _____ Night Sweats                   | _____ Lower Abdominal Pain <b>Left or Right</b> _____ |
| _____ Fatigue                        | _____ Yellow Jaundice                                 |
| _____ Weight changes                 | _____ Painful Urination                               |
| _____ Vision changes                 | _____ Blood in urine                                  |
| _____ Double vision                  | _____ Straining on urination                          |
| _____ Hearing loss                   | _____ Kidney Stones                                   |
| _____ Ringing in ears                | _____ Pelvic Pain                                     |
| _____ Ear problems                   | _____ Vaginal discharge/bleeding                      |
| _____ Bloody nose                    | _____ Joint or muscle pain                            |
| _____ Nasal discharge                | _____ Decreased mobility, weakness                    |
| _____ Sinusitis                      | _____ Joint swelling                                  |
| _____ Sore throat                    | _____ Skin Rash                                       |
| _____ Hoarseness                     | _____ Itching   |
| _____ Mouth sores                    | _____ Mole changes                                    |
| _____ Chest pain                     | _____ Loss of hair                                    |
| _____ Palpitations                   | _____ Difficulty w/ nails                             |
| _____ Ankle swelling                 | _____ Breast lumps, pain                              |
| _____ Calf pain                      | _____ Nipple discharge                                |
| _____ Short of breath                | _____ Headache or migraines                           |
| _____ Short of breath with exertion  | _____ Dizziness                                       |
| _____ Short of breath worse at night | _____ Seizures  |
| _____ Irregular pulse                | _____ Fainting  |
| _____ Wheezing                       | _____ Numbness or tingling                            |
| _____ Cough                          | _____ Memory loss                                     |
| _____ Coughing blood                 | _____ Anxiety   |
| _____ Diarrhea                       | _____ Depression                                      |
| _____ Constipation                   | _____ Suicidal thoughts                               |
| _____ Stool incontinence             | _____ Excessive hair growth                           |
| _____ Black Tar Stools               | _____ Excessive thirst                                |
| _____ Blood in stool                 | _____ Excessive urination                             |
| _____ Difficulty swallowing          | _____ Easy bruising                                   |
| _____ Heartburn                      | _____ Easy Bleeding                                   |
| _____ Nausea                         | _____ Swollen nodes                                   |
| _____ Vomiting                       |   |
| _____ Vomiting Blood                 |   |