Patient: _____ DOB: _____ Pediatric < 18

(Please use pencil to complete this form.)

FAMILY HISTORY

1. Is there any heart disease in your family history? Yes No Unknown
   If yes, circle the problem: High blood pressure, heart attack, high cholesterol, coronary artery bypass, stent placement.
2. Is there any diabetes in your family history? Yes No Unknown
3. Is there any cancer in your family history? Yes No Unknown
   If yes: what type of cancer(s)? _____
4. Is there any osteoporosis in your family history? Yes No Unknown
5. Is there any asthma/emphysema in your family history? Yes No Unknown

SOCIAL HISTORY

1. Do you use seatbelts/car seats? Yes No
2. Do you use ear protection when exposed to loud noises? Yes No
3. Are there any issues with violence or abuse in your life, past or present? Yes No
4. Do you follow good gun safety measures in your household? Yes No N/A
5. Do you use smoke detectors in your house? Yes No
6. Do you use CO detectors? Yes No N/A
7. Do you suffer from depression? Yes No
8. Does anyone in the house smoke cigarettes or cigars? Yes No
9. Do you follow a good diet with lots of fruits and vegetables and limited fat? Yes No
10. Do you currently have a weight problem? Yes No
11. Do you participate in any unique activities/challenges which are hazardous to your health? Yes No
    If yes, what? _____
12. Does anyone in the patient's household use alcohol? Yes No
13. Have you had an eye exam within the past two years? Yes No
14. Have you had a dental exam in the past year? Yes No
15. Have you had your hearing tested in the last two years? Yes No

IMMUNIZATIONS

Dtap: _____ _____ _____ _____ _____
OPV/IPV: _____ _____ _____ _____
HIB: _____ _____ _____ _____
Hep B: _____ _____ _____
MMR: _____ _____
Prevnar: _____ _____ _____ _____
DT: _____
Varivax: _____
Meningococcal: _____

Patient: _____ DOB: _____ Pediatric < 18

(Please use pencil to complete this form.)

REVIEW OF SYSTEMS

1. Have you had any problems with your skin or moles that are changing? _____
   _____
2. Have you had any bone, joint or muscle aches or pains? _____
   _____
3. Have you had any fatigue, weakness or bleeding disorders? _____
   _____
4. Have you had any vision changes, headaches or dizziness? _____
   _____
5. Have you had any problems involving your ears, nose or throat? _____
   _____
6. Have you had any difficulty breathing, wheezing or respiratory problems? _____
   _____
7. Have you had any chest pain, palpitations, or other heart problems? _____
   _____
8. Have you had any problems with your digestive system? _____
   _____
9. Have you had any problems urinating? _____
   _____
10. Are there any other health problems you have been having? _____
    _____

UPDATED: _____/_____/_____/_____/_____
_____/_____/_____/_____/_____