PATIENT NAME:_____ **DOB:**_____

PERSONAL & FAMILY HISTORY (MARK THOSE THAT APPLY)

Disease	Self	Mother	Father	Maternal Grandma	Maternal Granddad	Paternal Grandma	Paternal Granddad	Brothers/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/lung problems									
Blood clots									
Bloody stools/colon polyp									
Cancer									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney disease/UTIs									
Liver disease									
Loss of urine									
Mental illness									
Osteoporosis									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Other									

REVIEW OF SYSTEMS:
Please indicate if you are having any current problems in the following areas by marking an X in the appropriate column.

	No	Yes		No	Yes
General Wellness	____	____	Muscles/joints/bones	____	____
Eyes	____	____	Skin	____	____
Ear, nose, throat	____	____	Neurological	____	____
Heart/circulation	____	____	Psychiatric	____	____
Lungs/Breathing	____	____	Endocrine	____	____
Stomach/Digestion	____	____	Blood/Lymph	____	____
Reproduction/urinary	____	____	Allergies	____	____

Completed by _____ Signature _____ Date _____

Reviewed by _____ Provider signature _____ Date _____