Social History (Circle answer)

Marital Status: Married Single Divorced Widowed Separated Unknown

Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker
Never Smoker Smoker/status unknown Unknown if ever Smoked

How much do you/did you smoke? _____ For how many years did/have you smoked? _____

Do you Drink Alcohol? Yes Not Any More Never Drank

Type(s) of alcohol consumed: Beer Wine Alcohol **Drinking Habit:** Social Light Moderate Excessive

How many caffeinated drinks to you have each day? 0 1 2 3 4+ **Have you had a blood transfusion?** Yes No

Language English Spanish French German Portuguese Russian Chinese Japanese Italian Other

Race White Black/ African American American Indian/Alaska Native Eskimo Hispanic
Asian Pacific Islander Unknown

Review of Systems (Circle all that apply)

Constitutional: Fever Weight Loss Chills Other:_____

Eyes: Blurry Vision Double Vision Cataracts Other: _____

Ears, Nose Mouth and throat: Hearing Loss Nasal Stuffiness Sore Throat Other:_____

Cardiovascular: Chest Pain Swollen Ankles Irregular Heartbeat Other:_____

Respiratory: Shortness of Breath Wheezing Chronic Cough Other:_____

Gastrointestinal: Abdominal Pain Nausea/Vomiting Change in Bowels Other: _____

Genitourinary: Painful Urination Blood in Urine Incontinence Other: _____

Musculoskeletal: Chronic back pain Chronic neck pain Sore Muscles Other: _____

Integumentary/Skin : Rash Persistent Itching Skin Cancer History Other: _____

Neurological: Numbness Tingling Dizziness Other: _____

Hematologic/Lymphatic: Swollen Glands Transfusion History Abnormal Bleeding Other: _____