

PLEASE PRINT AND EXPLAIN YOUR ANSWERS AS INDICATED

Name: _____

Date of Birth _____ SS# _____

Current Medications	LIST ATTACHED	DOSE	None _____

Allergies to Medication	Reaction	None _____

Surgeries/Hospitalizations	LIST ATTACHED	YEAR	Complications

Ever had general anesthesia? No Yes _____ Any Problems? No Yes _____

List any major medical problems in your family's history: (i.e. hypertension, cancer, heart disease, arthritis, etc.) None _____

Updated:

Review of Systems:

Are you currently having or have you had problems with: Please describe all "Yes" responses

Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movements	No	Yes	_____
Bladder	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Heart Disease	No	Yes	_____
Bleeding	No	Yes	_____
Balance	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Psychological State	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Osteoporosis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy/Seizures	No	Yes	_____
Skin/Rashes	No	Yes	_____

Social History

Do you live alone? No _____ Yes _____

Children? No _____ Yes _____ Age(s): _____

Exercise? No _____ Yes _____ times per week _____ times per month _____ rarely

Type of exercise? _____

Special Diet? No _____ Yes _____

Substance Abuse? No _____ Yes _____

Smoke currently? No _____ Yes _____ packs per day for _____ years

Previously smoked? No _____ Yes _____ packs per day for _____ years; Quit smoking? _____ years ago

Drink alcohol? No _____ Yes _____ drinks per: _____ day _____ week _____ month _____ year _____ rarely

Patient Name: _____

Completed by: _____ Relationship to Patient: _____
If NOT by patient

Reviewed by: _____ Date: _____
Neal L. Rockowitz, M.D.