





**Social History**

Tobacco \_ No \_ Yes \_ Quit / when \_\_\_\_\_ Packs per day \_\_\_\_\_ # Years \_\_\_\_\_  
Alcohol \_ No \_ Yes \_ Quit / when \_\_\_\_\_ Drinks per wk \_\_\_\_\_ # Years \_\_\_\_\_  
Recreational Drug Use \_ No \_ Yes \_ Quit / when \_\_\_\_\_ \_ Used needles Drugs used \_\_\_\_\_  
Diet \_ vegetarian \_ lactose-free \_ caffeine-free \_ diabetic \_ regular \_ other \_\_\_\_\_

Marital Status \_ Married \_ Single \_ Divorced \_ Widow/Widower \_ Occupation \_\_\_\_\_

**Family History:** (include age of diagnosis in affected family member)

	Father	Mother	Brother/Sister	Other/ Other Generations
Colon cancer	_____	_____	_____	_____
Colon polyp	_____	_____	_____	_____
Uterine/ovarian cancer	_____	_____	_____	_____
Stomach/small bowel cancer	_____	_____	_____	_____
Renal/ ureteral cancer	_____	_____	_____	_____
Breast cancer	_____	_____	_____	_____
Liver disease/ Hemochromatosis	_____	_____	_____	_____
Gallbladder disease	_____	_____	_____	_____
Colitis/Crohn's disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Review of Systems** (check if you have any of the following and describe further in space below)

**Gastrointestinal**

- Y  N Heartburn/regurgitation
- Y  N Difficulty swallowing
- Y  N Painful swallowing
- Y  N Filling up quickly at meals
- Y  N Nausea or vomiting
- Y  N Abdominal pain
- Y  N Irregular bowel habits
- Y  N Bloating/gas
- Y  N Incomplete evacuation of bowels
- Y  N Symptoms improve with evacuation
- Y  N Blood in stool or on toilet paper
- Y  N Mucous in stool
- Y  N Loss of control of bowels

- Y  N Intolerance to milk
- Y  N Intolerance to other foods
- Y  N Jaundice
- Y  N Gallstones
- Y  N Hepatitis A, B, C, other
- Y  N Cirrhosis
- Y  N Fluid in abdomen (ascites)
- Y  N Pancreatitis

**Skin**

- Y  N Rash
- Y  N Itching
- Y  N Unusual hair loss

**General**

- Y  N Decreased appetite
- Y  N Unexpected weight loss
- Y  N Unexpected weight gain
- Y  N Fatigue
- Y  N Fever or Chills

**Eyes**

- Y  N Blind field of vision
- Y  N Cataracts

**ENT**

- Y  N Hearing loss/ ringing
- Y  N Sore throat/hoarseness
- Y  N Sinusitis/Sinus drainage

**Respiratory/Lung**

- Y  N Sleep apnea / CPAP mask
- Y  N Respiratory complications with sedation
- Y  N Chronic bronchitis/emphysema
- Y  N Difficulty breathing
- Y  N Persistent cough
- Y  N Asthma

**Cardiovascular**

- Y  N Chest pain, pressure, angina
- Y  N Coronary artery disease
- Y  N High blood pressure
- Y  N Swelling in feet or legs
- Y  N Abnormal heart rhythm
- Y  N Prostate cancer/enlarged

**Renal/Urinary/Kidney**

- Y  N Renal failure/insufficiency
- Y  N Electrolyte disturbances
- Y  N Kidney stones
- Y  N Difficulty with urination
- Y  N Urinary tract infections

**Endocrine**

- Y  N Diabetes
- Y  N Thyroid disease
- Y  N Osteoporosis/osteopenia

**Gynecology**

- Y  N Pregnant now?
- Y  N Endometriosis
- Y  N Heavy periods

**Musculoskeletal**

- Y  N Joint pain/arthritis
- Y  N Back / neck pain
- Y  N Muscle aching/weakness

**Neurologic**

- Y  N Headaches
- Y  N Strokes/ CVA
- Y  N Seizures

**Psychiatric**

- Y  N Depression
- Y  N Anxiety
- Y  N Suicide attempt
- Y  N Swollen/tender lymph node

**Blood / Lymph**

- Y  N Anemia
- Y  N Bruise easily
- Y  N Past blood transfusion

Comments \_\_\_\_\_  
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