Social History	Vaccines	When?	Current Medications
Are you Married? Do you have children? How many?_____ Occupation:_____ Place of Birth:_____ Do you exercise regularly? Special Diet? Do you travel outside the US? What countries?_____ Do you currently smoke? How much? Did you smoke in the past? Do you use alcohol?	Flu Pneumonia Chicken Pox Shingles MMR Tetanus Tuberculosis Hepatitis A Hepatitis B Meningitis HPV		

Current or Recent Symptoms or Complaints		
Fatigue Unexplained weight loss Night sweats Unexplained fever Vision loss Eye pain Double vision Dental problems Frequent sinus infections Ringing in ears Ear drainage Loss of smell Frequent nasal congestion Nose bleeds Frequent sore throat Hoarseness Neck pain or stiffness Chest pain Passed out/fainted Swelling Circulation problems Heart palpitations Shortness of breath	Pain in calves when walking Persistent cough Coughing up blood Wheezing Excessive thirst Menstrual problems Excessive hair growth Intolerance to heat or cold Swelling of lymph nodes/glands Loss of appetite Difficulty swallowing Heartburn/Acid reflux Abdominal pain Choking Food gets stuck in throat Diarrhea Blood with bowel movement Vomiting/nausea Black/tarlike bowel movements Constipation Leaking urine Pain with urination Excessive nighttime urination	Blood in urine Erectile Dysfunction Vaginal discharge Pain with sex Rash Atypical moles Hives Excessive bruising Breast lump or pain Nipple discharge Testicular lump or pain Headaches Seizures Memory loss Stroke symptoms Numbness or tingling Sleeplessness Depressed mood Muscle cramps Weakness Joint pain Joint swelling

Notes: