

HISTORY / REVIEW OF SYSTEMS

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Please indicate any personal history below:

Patient Name: _____

MEDICAL PROBLEMS	CURRENT MEDICATION	HOSPITALIZATIONS or SURGERIES (Aprox. Year)	ALLERGIES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONSTITUTIONAL SYMPTOMS Good general health lately N Y Recent weight change N Y Fever N Y Fatigue N Y Headaches N Y	MUSCULOSKELETAL Joint pain N Y Joint stiffness or swelling N Y Weakness of muscles or joints N Y Muscle pain or cramps N Y Back Pain N Y Cold extremities N Y Difficulty in walking N Y	EYES Eye disease or injury N Y Glasses/contact lenses N Y Blurred or double vision N Y Glaucoma N Y
EAR/NOSE/MOUTH/THROAT Hearing loss or ringing N Y Earaches or drainage N Y Chronic sinus problem or rhinitis N Y Nose bleeds N Y Mouth sores N Y Bleeding gums N Y Bad breath or bad taste N Y Sore throat or voice change N Y Swollen glands in neck N Y	INTEGUMENTARY (skin, breast) Rash or itching N Y Change in skin color, hair or nails N Y Varicose veins N Y Breast pain N Y Breast lump N Y Breast discharge N Y	PSYCHIATRIC Memory loss or confusion N Y Nervousness N Y Depression N Y Insomnia N Y
ENDOCRINE Glandular or hormone problem N Y Thyroid disease N Y Diabetes (<i>Insulin or non-Insulin</i>) N Y Excessive thirst or urination N Y Heat or cold intolerance N Y Skin becoming dryer N Y Change in hat or glove size N Y	NEUROLOGICAL Frequent or recurring headaches N Y Light headed or dizzy N Y Convulsions or seizures N Y Numbness or tingling sensations N Y Tremors N Y Paralysis N Y Stroke N Y Head Injury N Y	RESPIRATORY Chronic or frequent coughs N Y Spitting up blood N Y Shortness of breath N Y Asthma or Wheezing N Y
HEMATOLOGIC / LYMPHATIC Slow to heal after cuts N Y Bleeding/bruising tendency N Y Anemia N Y Phlebitis N Y Past transfusion N Y Enlarged glands N Y		

GASTROINTESTINAL Loss of appetite N Y Change in bowel movements N Y Nausea or vomiting N Y Frequent diarrhea N Y Painful bowel movements or constipation N Y Rectal bleeding or blood in stool N Y Abdominal pain N Y Peptic ulcer (stomach or duodenal) N Y	CARDIOVASCULAR Heart trouble N Y Chest pain or angina pectoris N Y Palpitation N Y Shortness of breath with walking or lying flat N Y Swelling of feet, ankles or hands N Y High blood pressure N Y
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GENITOURINARY Frequent urination N Y Burning or painful urination N Y Blood in urine N Y Change in force of strain when urinating N Y Incontinence or dribbling N Y Kidney stones N Y Sexual difficulty N Y Male - testicle pain N Y	Female - pain with periods N Y Female - irregular periods N Y Female - vaginal discharge N Y Female - hysterectomy N Y Female - tubal ligation N Y Female - # of pregnancies _____ Female - # of miscarriages _____ Female - date of last pap smear _____
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FAMILY HISTORY (Please circle as applies)

Heart Disease	High Blood Pressure	Stroke	Cancer	Glaucoma	Diabetes	Epilepsy/convulsions	Bleeding Disorder	Kidney Disease	Thyroid Disease	Mental Illness	Osteoporosis
Father	Father	Father	Father	Father	Father	Father	Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother
Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents
Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents
Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings
Children	Children	Children	Children	Children	Children	Children	Children	Children	Children	Children	Children

Reviewed By: _____ Date: _____