MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:________________NAME:____DATE OF BIRTH___________
____MARRIED ____SINGLE ____DIVORCED ____WIDOWED; OCCUPATION:__________________________
NO.OF CHILDREN:____TOBACCO USE: YES/NO HOW MUCH?______/DAY HOW LONG? DATE QUIT_____
ALCOHOL USE: HOW MUCH PER DAY?_______CAFFEINE (COFFEE,TEA,COLAS) PER DAY_____________

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY
- ☐ ☐ ALCOHOLISM
- ☐ ☐ ANEMIA
- ☐ ☐ ASTHMA
- ☐ ☐ CANCER/TUMOR
- ☐ ☐ DIABETES
- ☐ ☐ DRUG ABUSE
- ☐ ☐ DEPRESSION
- ☐ ☐ EPILEPSY/SEIZURES
- ☐ ☐ GLAUCOMA
- ☐ ☐ HEART DISEASE

YOU/YOUR FAMILY
- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ KIDNEY DISEASE
- ☐ ☐ LIVER DISEASE
- ☐ ☐ HEPATITIS
- ☐ ☐ LUNG DISEASE
- ☐ ☐ MENTAL ILLNESS
- ☐ ☐ OSTEOARTHRITIS
- ☐ ☐ OSTEOPOROSIS
- ☐ ☐ PHLEBITIS
- ☐ ☐ RHEUMATIC ARTHRITIS

YOU/YOUR FAMILY
- ☐ ☐ STROKE
- ☐ ☐ SUICIDE ATTEMPT
- ☐ ☐ THYROID DISEASE
- ☐ ☐ TUBERCULOSIS, TB
- ☐ ☐ ULCER IN GI TRACT
- ☐ ☐ VENEREAL DISEASE
- ☐ ☐ HIGH CHOLESTEROL
- ☐ ☐ HIV/IMMUNE DX
- ☐ ☐ OTHER

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

____
____
____
____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL: Yes No
- Weight Loss ☐ ☐
- Fatigue ☐ ☐
- Fever ☐ ☐

EYES:
- Glasses/Contacts ☐ ☐
- Eye Pain ☐ ☐
- Double Vision ☐ ☐
- Cataracts ☐ ☐

EAR,NOSE,THROAT:
- Difficulty Hearing ☐ ☐
- Ringing in Ears ☐ ☐
- Vertigo ☐ ☐
- Sinus Trouble ☐ ☐
- Nasal Stuffiness ☐ ☐
- Frequent Sore Throat ☐ ☐

CARDIOVASCULAR:
- Murmur ☐ ☐
- Chest Pain ☐ ☐
- Palpitations ☐ ☐
- Dizziness ☐ ☐
- Fainting Spells ☐ ☐
- Shortness of Breath ☐ ☐
- Difficulty lying Flat ☐ ☐
- Swelling Ankles ☐ ☐

ENDOCRINE:
- Loss of Hair ☐ ☐
- Heat/Cold Intolerance ☐ ☐

RESPIRATORY Yes No
- Cough ☐ ☐
- Coughing Blood ☐ ☐
- Wheezing ☐ ☐
- Chills ☐ ☐

GASTROINTESTINAL:
- Heartburn/Reflux ☐ ☐
- Nausea/Vomiting ☐ ☐
- Constipation ☐ ☐
- Change in BMs ☐ ☐
- Diarrhea ☐ ☐
- Jaundice ☐ ☐
- Abdominal Pain ☐ ☐
- Black or Bloody BM ☐ ☐

GENITOURINARY:
- Burning/Frequency ☐ ☐
- Nighttime ☐ ☐
- Blood in Urine ☐ ☐
- Erectile Dysfunction ☐ ☐
- Abnormal Discharge ☐ ☐
- Bladder Leakage ☐ ☐

ALLERGIC/IMMUNOLOGIC:
- Hives/Eczema ☐ ☐
- Hay Fever ☐ ☐

PSYCHIATRIC:
- Anxiety/Depression ☐ ☐
- Mood Swings ☐ ☐
- Difficult Sleeping ☐ ☐

HEMATOLOGY/LYMPH YesNo
- Easy Bruising ☐ ☐
- Gums Bleed Easily ☐ ☐
- Enlarged Glands ☐ ☐

MUSCULOSKELETAL:
- Joint Pain/Swelling ☐ ☐
- Stiffness ☐ ☐
- Muscle Pain ☐ ☐
- Back Pain ☐ ☐

SKIN:
- Rash/Sores ☐ ☐
- Lesions ☐ ☐
- Itching/Burning ☐ ☐

NEUROLOGICAL:
- Loss of Strength ☐ ☐
- Numbness ☐ ☐
- Headaches ☐ ☐
- Tremors ☐ ☐
- Memory Loss ☐ ☐

FEMALES ONLY:

Date Last Mammogram _______
Normal Abnormal _______
Date last PAP__________________
Normal_____Abnormal__________
Age Onset Periods
Age Onset Menopause_
Periods Regular? Yes No____
Number Pregnancies_____________

SIGNATURE/REVIEWING PHYSICIAN____

NEW PATIENT- PLEASE COMPLETE THE FOLLOWING

Name:______________________________Date:________________________

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS,VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?	NEED RX
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO

PREFERRED PHARMACY:__________________LOCATION:__________________

PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:

NAME	CITY/STATE	PROBLEM CARED FOR:	STILL SEEING?	REFERRAL?
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION:	ADVERSE REACTION

ADDITIONAL INFORMATION:

LAST MAMMOGRAM?__________WHERE?________LAST PAP?__________GYN?_________

PHYSICIAN TO PERFORM FUTURE PAPS? YES_______________ NO:________________

LAST COLONOSCOPY?_________NORMAL?______DR?_________REPEAT DATE?__________

APPROXIMATE DATE OF LAST BLOODWORK?______________RECTAL EXAM?____________

VACCINE DATES:

TETANUS?_________PNEUMONIA?__________FLU?__________HEPATITIS B SERIES?_______