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	YOU/YOUR FAMILY	YOU/YOUR FAMILY
☐ ☐ ALCOHOLISM	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ STROKE
☐ ☐ ANEMIA	☐ ☐ KIDNEY DISEASE	☐ ☐ SUICIDE ATTEMPT
☐ ☐ ASTHMA	☐ ☐ LIVER DISEASE	☐ ☐ THYROID DISEASE
☐ ☐ CANCER/TUMOR	☐ ☐ HEPATITIS	☐ ☐ TUBERCULOSIS, TB
☐ ☐ DIABETES	☐ ☐ LUNG DISEASE	☐ ☐ ULCER IN GI TRACT
☐ ☐ DRUG ABUSE	☐ ☐ MENTAL ILLNESS	☐ ☐ VENEREAL DISEASE
☐ ☐ DEPRESSION	☐ ☐ OSTEOARTHRITIS	☐ ☐ HIGH CHOLESTEROL
☐ ☐ EPILEPSY/SEIZURES	☐ ☐ OSTEOPOROSIS	☐ ☐ HIV/IMMUNE DX
☐ ☐ GLAUCOMA	☐ ☐ PHLEBITIS	☐ ☐ OTHER_____
☐ ☐ HEART DISEASE	☐ ☐ RHEUMATIC ARTHRITIS	

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	Yes	No
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

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

CHIEF COMPLAINT AND ADDITIONAL INFORMATION: