MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE: _____ NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED; OCCUPATION: _____
OF CHILDREN _____ TOBACCO USE: Yes/No HOW MUCH? _____ /DAY HOW LONG? _____ DATE QUIT? _____
ALCOHOL USE: YES/NO HOW MUCH PER DAY? _____ CAFFEINE (COFFEE, TEA, COLAS) PER DAY? _____

PAST ILLNESSES OF YOURSELF AND YOUR FAMILY:

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

RESPIRITORY:	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	( )	( )

HEMOTOLOGY/LYMPHY:	YES	NO
Easy Bruising	( )	( )
Gums Bleed Easily	( )	( )
Enlarged Glands	( )	( )
MUSCULOSKELETEL:		
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 of Last Mammogram: _____
Normal: _____ Abnormal _____
Date of Last Pap: _____
Normal: _____ Abnormal _____
Age Onset Periods: _____
Age Onset Menopause: _____
Periods Regular? Yes _____ No _____
Number of 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 THE 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
			YES/NO	YES/NO

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION	ADVERSE REACTION

HOW DID YOU ABOUT OUR CLINIC?

_____