

**PAST MEDICAL HISTORY**

Please list all the Surgeries or Hospitalizations you have had:

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current Medical Conditions or Illnesses for which you are being treated or followed by a physician:

Condition or Diagnosis	Date of Onset	Physician or Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other significant Past Illnesses or Injuries from which you have completely recovered:

Injury/Illness/Diagnosis	Date
_____	_____
_____	_____
_____	_____

**FAMILY HISTORY**

	Who?		Who?
Alzheimer's Disease <input type="checkbox"/> Y <input type="checkbox"/> N	_____	High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	_____	High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Blood Disease <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Mental Illness <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Depression <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Migraines <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Cancer <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Osteoarthritis <input type="checkbox"/> Y <input type="checkbox"/> N	_____
CVA (stroke) <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N	_____

**REVIEW OF SYSTEMS**

Circle any item that relates to your current state of health: (Leaving an item unmarked indicates a NEGATIVE response)

<u>GENERAL HEALTH</u>	<u>RESPIRATORY</u>	<u>GASTROINTESTINAL</u>	<u>REPRODUCTIVE</u>	<u>NEUROLOGICAL</u>	<u>INTEGUMENTARY</u>
Chills	Chronic cough	Abdominal pain	Abnormal pap	Dizziness	Contact allergy
Fatigue	Cough	Blood in stools	Breast discharge	Extremity numbness	Hives
Fever	Known TB exposure	Change in stool	Breast lump	Extremity weakness	Itching
Malaise	Shortness of breath	Constipation	Painful menstruation	Gait disturbance	Mole changes
Night sweats	Wheezing	Diarrhea	Painful intercourse	Headache	Rash
Weight gain	<b>Other:</b>	Heartburn	Hot flashes	Memory loss	Skin lesion
Weight loss	Apnea	Loss of appetite	Irregular menses	Seizures	<b>Other:</b>
<b>Other:</b>	Asthma	Nausea	Vaginal discharge	Tremors	Acne
Exercise intolerance	Coughing blood	Vomiting	<b>Other:</b>	<b>Other:</b>	Eczema
Change in appetite	Painful respirations	<b>Other:</b>	Fibroids	Altered mental status	Skin infection
Irritability	Respiratory infections	Acid reflux	Genital lesions	Confusion/disorientation	
	Trouble breathing	Fecal incontinence	Infertility	Facial droop	<u>MUSCULOSKELETAL</u>
		Hemorrhoids	Ovarian cysts	Focal weakness	Back pain
		Rectal bleeding	Vaginal dryness	Frequent falls	Joint pain
			Vaginal itching	Speech changes	Joint swelling
				Trouble speaking	Muscle weakness
					Neck pain
<u>HEENT</u>	<u>CARDIOVASCULAR</u>	<u>GENITOURINARY</u>	<u>METABOLIC/</u>	<u>PSYCHIATRIC</u>	<b>Other:</b>
Ear drainage	Chest pain	Dribbling	<u>ENDOCRINE</u>	Anxiety	Arthritis
Ear pain	Leg pain w/ walking	Painful urination	Brittle hair	Depression	Osteoporosis
Eye discharge	Edema	Blood in urine	Brittle nails	Insomnia	
Eye pain	Palpitations	Excessive urination	Cold intolerance	<b>Other:</b>	<u>HEMATOLOGIC/</u>
Hearing loss	<b>Other:</b>	Slow stream	Hair changes	Behavior changes	<u>LYMPHATIC</u>
Nasal drainage	Irregular heart beat	Urinary frequency	Heat intolerance	Difficulty concentrating	Easy bleeding
Sinus pressure	Loss of consciousness	Urinary incontinence	Abnormal hair growth	Difficulty sleeping	Easy bruising
Sore throat	Tingling in extremity	Urinary retention	Excessive thirst	Excessive stress	Swollen lymph nodes
Visual changes		<b>Other:</b>	Excessive hunger	Problems coping	
<b>Other:</b>		Flank pain	Kidney stones	Suicidal thoughts	<u>IMMUNOLOGIC</u>
Difficulty Swallowing		Foul urine odor	Recurrent UTI		Environmental allergies
Double vision					Food allergies
Jaw pain					Seasonal allergies
Mouth ulcers					
Ring in ears					
Sensitivity to light					
Snoring					
Tooth pain					