

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)

GENERAL HEALTH

- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weight gain
- Weight loss
- Other:**
- Exercise intolerance
- Change in appetite
- Irritability

HEENT

- Ear drainage
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Nasal drainage
- Sinus pressure
- Sore throat
- Visual changes
- Other:**
- Difficulty Swallowing
- Double vision
- Jaw pain
- Mouth ulcers
- Ringin in ears
- Sensitivity to light
- Snoring
- Tooth pain

RESPIRATORY

- Chronic cough
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing
- Other:**
- Apnea
- Asthma
- Coughing blood
- Painful respirations
- Respiratory infections
- Trouble breathing

CARDIOVASCULAR

- Chest pain
- Leg pain w/ walking
- Edema
- Palpitations
- Other:**
- Irregular heat beat
- Loss of consciousness
- Tingling in extremity

GASTROINTESTINAL

- Abdominal pain
- Blood in stools
- Change in stool
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting
- Other:**
- Acid reflux
- Fecal incontinence
- Hemorrhoids
- Rectal bleeding

GENITOURINARY

- Dribbling
- Painful urination
- Blood in urine
- Excessive urination
- Slow stream
- Urinary frequency
- Urinary incontinence
- Urinary retention
- Other:**
- Flank pain
- Foul urine odor
- Kidney stones
- Recurrent UTI

REPRODUCTIVE

- Erectile dysfunction
- Penile discharge
- Sexual dysfunction
- Other:**
- Circumcised
- Genital lesions
- Blood in semen
- Infertility
- Painful ejaculation
- Testicular mass
- Testicular pain

METABOLIC/ ENDOCRINE

- Brittle hair
- Brittle nails
- Cold intolerance
- Hair changes
- Heat intolerance
- Abnormal hair growth
- Excessive thirst
- Excessive hunger
- Other:**
- Excessive perspiration
- Growth delay

NEUROLOGICAL

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors
- Other:**
- Altered mental status
- Confusion/disorientation
- Facial droop
- Focal weakness
- Frequent falls
- Speech changes
- Trouble speaking

PSYCHIATRIC

- Anxiety
- Depression
- Insomnia
- Other:**
- Behavior changes
- Difficulty concentrating
- Difficulty sleeping
- Excessive stress
- Problems coping
- Suicidal thoughts

INTEGUMENTARY

- Contact allergy
- Hives
- Itching
- Mole changes
- Rash
- Skin lesion
- Other:**
- Acne
- Eczema
- Skin infection

MUSCULOSKELETAL

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other:**
- Arthritis
- Osteoporosis

HEMATOLOGIC/ LYMPHATIC

- Easy bleeding
- Easy bruising
- Swollen lymph nodes

IMMUNOLOGIC

- Environmental allergies
- Food allergies
- Seasonal allergies