**Patient History and Review of Systems**

**Past Medical History** Check (✓) conditions you have or had in the past.

- AIDS/HIV
- Alcoholism
- Anemia
- Anorexia/Bulimia
- Arthritis
- Asthma/Bronchitis
- Bleeding Disorders
- Cancer
- Chemical Dependency
- Diabetes
- Emphysema
- Epilepsy
- Heart Disease
- Hepatitis
- Hernia
- High Cholesterol
- Kidney/Liver Disease
- Migraine Headaches
- Mononucleosis
- Multiple Sclerosis
- Pneumonia
- Psychiatric Care
- STD
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Ulcers

**Social History** Check (✓) and describe all that apply.

- Alcohol: Type __________ Amount ________ Frequency ________
- Antacids: Type _____ Used For: ________ Frequency ________
- Tobacco Use: Type ______ Amount Daily ________ Frequency ________
- Caffeine: Type ______ Amount Daily ________ Frequency ________
- Exercise: Regularly ______ Yes ______ No ______ Activity ______ Frequency ________

**Family History** Please explain Whom in your family has the following.

- Diabetes: ________
- Cancer: ________
- Thyroid Disease: ________

**Past Surgeries and Hospitalizations** (with year of occurrence).

**Current Medications**

**Allergies to Medications**

**Reason for Visit**

**Review of Systems** Check (✓) symptoms you currently have or recently had.

**Eyes**
- Eye disease or injury
- Vision changes
- Wear glasses/contact lenses

**Ear, Nose, Throat**
- Bleeding gums
- Tongue Problems
- Difficulty swallowing
- Earache
- Ear discharge
- Hay fever or allergies
- Hearing loss
- Hoarseness
- Lump in the neck
- Mouth sore
- Nasal discharge
- Nasal stuffiness
- Neck pain
- Nose bleeding
- Cough
- Ringing in ears
- Sinus problems
- Snoring
- Sore throat

**General**
- Chills
- Fatigue
- Fever
- Headache
- Loss of appetite
- Loss of weight
- Sweats

**Cardiovascular**
- Chest pain
- High or low blood pressure
- Irregular or rapid heart beat
- Poor circulation
- Varicose veins

**Respiratory**
- Spitting up blood
- Shortness of breath
- Asthma or wheezing

**Genito-Urinary**
- Blood in urine
- Frequent or painful urination
- Lack of bladder control

**Gastrointestinal**
- Black or tarry stools
- Change in bowel movements
- Constipation
- Diarrhea
- Excessive hunger or thirst
- Indigestion or heartburn
- Loss of appetite
- Nausea or vomiting
- Stomach pain
- Vomiting blood

**Muscle/Joint/Bone**
- Pain, weakness, numbness in:
  - Arms or legs
  - Back or body
  - Joints

**Neurological**
- Tremors
- Paralysis
- Stroke
- Head injury

**Endocrine**
- Glandular or hormone problem
- Diabetes (insulin or non insulin)
- Change in hat or glove size

**Hematologic/Lymphatic**
- Slow to heal after cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion

**Skin**
- Change in hair or nails
- Hives
- Itching
- Rash
- Scars
- Sore that won't heal

Date of last physical exam

**Are you pregnant?** Yes ☐ No ☐