SYSTEMS REVIEW and PAST MEDICAL HISTORY

Patient Name _____
Date Completed _____ Age: _____
Date of Birth _____ Sex M F
Height _____ Weight _____
RIGHT HANDED _____ **LEFT HANDED** _____

PAST MEDICAL HISTORY
Do you have any of these medical conditions?

1. Cardiac
- a. **Hypertension/High Blood Press** YES NO
- b. Heart Attack YES NO
- c. Stroke YES NO
- d. Blood Clots YES NO
- e. Arrhythmia YES NO
- f. High Cholesterol YES NO
- g. Other _____

2. Respiratory
- a. Asthma YES NO
- b. Sleep Apnea (diagnosed) YES NO
- c. Other _____

3. Gastrointestinal
- a. Ulcer Disease YES NO
- b. Other _____

4. Endocrine
- a. Thyroid Problem YES NO
- b. Diabetes YES NO
  - i. Insulin? YES NO
  - ii. Medication? YES NO
  - iii. Diet Controlled? YES NO

5. Cancer YES NO
- a. Type _____
- b. Treatment _____

6. Liver Disease YES NO
- a. _____

7. Neurological Disease YES NO
- a. Seizure Disorder YES NO
- b. Parkinson's Disease YES NO
- c. Multiple Sclerosis YES NO
- d. Other _____

8. Kidney Disease YES NO
- a. _____

9. Malignant Hypertension YES NO
(Surgery Complication)

10. HIV/AIDS YES NO

11. Other (list)
- a. _____
- b. _____
- c. _____

PAST SURGICAL HISTORY
List all operations that you have had
1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY - If "Yes" please circle family member(s)
1. Heart YES NO
   Father / Mother / Brother / Sister
2. Lung YES NO
   Father / Mother / Brother / Sister
3. Cancer YES NO
   Father / Mother / Brother / Sister
4. Diabetes YES NO
   Father / Mother / Brother / Sister
5. Hypertension YES NO
   Father / Mother / Brother / Sister
6. Other _____
   Father / Mother / Brother / Sister

SOCIAL HISTORY
1. Tobacco YES NO
   a. Packs per day _____
2. Alcohol YES NO
   a. Frequency _____
3. Caffeine YES NO
   a. Cups per day _____
4. Do you or have you had a problem with chemical dependency? YES NO
5. Are you or could you be pregnant? YES NO

OCCUPATION
1. Employer _____
2. Job Description _____
3. Years Employed _____

ALLERGIES
1. General
   - a. Latex YES NO
   - b. Metal YES NO
   - c. Chicken Products YES NO
   - d. Other (test dyes, shellfish) _____

*** PATIENT NAME _____

REVIEW OF SYMPTOMS

Do you have any of the following problems?

1. Constitutional		
a. Recent Weight Loss	YES	NO
b. Fevers	YES	NO
c. Chills	YES	NO
d. Night Sweats	YES	NO
2. Eyes		
a. Blurred Vision	YES	NO
b. Glasses	YES	NO
3. ENT - Ear(s)	YES	NO
Nose	YES	NO
Throat	YES	NO
4. Respiratory		
a. Shortness of Breath	YES	NO
b. Wheezing	YES	NO
c. Persistent Cough	YES	NO
5. Cardiovascular		
a. Chest Pain	YES	NO
b. Irregular Heartbeat	YES	NO
6. Gastrointestinal		
a. Stomach Pain	YES	NO
b. Blood in Stool	YES	NO
c. Frequent Diarrhea	YES	NO
d. Constipation	YES	NO
7. Genitourinary		
a. Blood in Urine	YES	NO
b. Painful Urination	YES	NO
c. Difficulty	YES	NO
d. Frequent Urinary Infections	YES	NO
8. Neurologic		
a. Paralysis	YES	NO
b. Frequent Headaches	YES	NO
9. Skin		
a. Rash	YES	NO
10. Psychiatric		
a. Depressed Mood	YES	NO
11. Blood		
a. Easy Bruising/Bleeding	YES	NO

TESTS PERFORMED	DATE	BODY PART/SIDE
1.		
2.		
3.		
4.		
5.		

DOCTORS' NAMES	PHONE
1.	
2.	
3.	

PHYSICIAN'S SIGNATURE DATE

Reviewed

Date of Last Vaccine

Flu Vaccine: _____ Pneumonia: _____

Medication Reconciliation

Medicine name/strength	Purpose	Dosage/frequency/time	Doctor

Medicines allergic to:

Any other notes/comments