MEDICAL HISTORY/REVIEW OF SYSTEMS

NAME__________________________________ DATE ______________

HEIGHT______________ WEIGHT______________ DOB ______________

TOBACCO USE? ______________ HOW MUCH?______________ HOW LONG?______________

ALCOHOL USE? ______________ HOW MUCH? ______________

DRUG USE? ____

LIST PAST SURGERIES (DATE AND SURGERY)______________________________

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HOSPITALIZATIONS IN PAST YEAR (WHY?) ______________________________

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PLEASE CIRCLE IF YOU HAVE:

WEIGHT LOSS	CHEST PAIN	BLOOD IN URINE/FECES	NUMBNESS
FATIGUE	HEART ATTACK	URINARY ISSUES	TINGLING
FEVER	FAINTING	ANXIETY	TREMORS
GLASSES/CONTACTS	SHORTNESS OF BREATH	DEPRESSION	MEMORY LOSS
CATARACTS	SWOLLEN ANKLES	BIPOLAR	PREGNANCY
BLINDNESS	BLOOD CLOTS	ALCOHOLISM	NURSING
DIFFICULTY HEARING	POOR CIRCULATION	EASY BRUISING	
HEADACHES/MIGRAINES	PERSISTANT COUGH	SWOLLEN GLANDS	
VERTIGO	COUGHING BLOOD	JOINT PAIN/SWELLING	
DIZZINESS	WHEEZING	MUSCLE PAIN	
SINUS PROBLEMS	HEARTBURN/GERD	BACK PAIN	
ALLERGIES	NAUSEA/VOMITING	MOLE CHANGES	
SORE THROAT	CONSTIPATION	RASH	
HEART MURMUR	DIARRHEA	ITCHING	
PALPITATIONS	JAUNDICE	ECZEMA/PSORIASIS	

PLEASE CIRCLE PAST ILLNESSES/ISSUES:

ALCOHOLISM	EPILEPSY/SEIZURES	HEPATITIS B OR C	VARICOSE VEINS	HIGH CHOLESTEROL
ANEMIA	GLAUCOMA	LUNG DISEASE	RHEUMATOID ARTHRITIS	HIV/AIDS
ASTHMA	HEART ATTACK	BIPOLAR	SKIN ISSUES	LUPUS
CANCER	HIGH BLOOD PRESSURE	SCHIZOPHRENIA	STROKE	OTHER IMMUNE
DIABETES	HEART DISEASE	OTHER MENTAL ISSUE	THYROID DISEASE	AMPUTATIONS
DRUG USE	KIDNEY DISEASE	OSTEOARTHRITIS	TUBERCULOSIS	OTHER
DEPRESSION/ANXIETY	LIVER DISEASE	OSTEOPOROSIS	STOMACH ULCERS	

PLEASE EXPLAIN ANY ABOVE CONDITIONS: ____

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CURRENT MEDICATIONS/DOSAGE

DRUG ALLERGIES/REACTION