MEDICAL HISTORY/REVIEW OF SYSTEMS

NAME_____ DATE _____

HEIGHT_____ WEIGHT_____ DOB_____

TOBACCO USE? _____ HOW MUCH?_____ HOW LONG?_____

ALCOHOL USE? _____ HOW MUCH? _____ HOW LONG?_____

LIST PAST SURGERIES (last 5 years)_____

_____

_____

_____

_____

HOSPITALIZATIONS IN PAST YEAR (WHY?)_____

_____

_____

PLEASE CIRCLE IF YOU HAVE:

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

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:_____

_____

_____

_____

_____

CURRENT MEDICATIONS/DOSAGE

DRUG ALLERGIES/REACTION
