

SYSTEM REVIEW:

PATIENT: _____

DOB: _____

DATE: _____

CONSTITUTIONAL SYMPTOMS:

Good general health lately	NO	YES
Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EARS/NOSE/MOUTH/THROAT

Hearing loss/ringing	NO	YES
Earaches or drainage	NO	YES
Chronic sinus problems	NO	YES
Nose/Mouth bleeding	NO	YES
Mouth Sores	NO	YES

HEART

Heart trouble	NO	YES
Chest pain or angina	NO	YES
Palpitation	NO	YES
Swelling feet, ankles, hands	NO	YES
Hypertension	NO	YES

BREATHING

Chronic or frequent coughs	NO	YES
Spitting up blood	NO	YES
Shortness of breath	NO	YES
Asthma or wheezing	NO	YES

BOWEL

Loss of appetite	NO	YES
Change in bowel movement	NO	YES
Nausea or vomiting	NO	YES
Frequent diarrhea	NO	YES
Abdominal pain	NO	YES

URINARY

Frequent urination	NO	YES
Blood in urine	NO	YES
Kidney Stone	NO	YES
Burning or painful urination	NO	YES

ALLERGIES**Do you have a history of skin reaction/other adverse reaction to:**

Penicillin or other antibiotics	NO	YES	NAME?:
Morphine, Demerol, other narcotics	NO	YES	NAME?:
Aspirin/other pain remedies	NO	YES	NAME?:
Novocaine/other anesthetics	NO	YES	NAME?:
Other drugs or other substances:	NO	YES	NAME?:

MUSCULOSKELETAL

Joint stiffness/pain	NO	YES
Muscle pain/cramps	NO	YES
Back Pain	NO	YES
Weak muscles/joints	NO	YES

SKIN

Rash or itching	NO	YES
Change in skin color	NO	YES
Breast Pain/Lump	NO	YES
Change in hair/nails	NO	YES

NEUROLOGICAL

Frequent headaches	NO	YES
Light headed/dizzy	NO	YES
Convulsions/seizure	NO	YES
Stroke	NO	YES
Head injury	NO	YES

PSYCHIATRIC

Memory loss	NO	YES
Depression	NO	YES
Insomnia	NO	YES
Nervousness	NO	YES

GLANDS

Hormone/gland prob.	NO	YES
Thyroid disease	NO	YES
Excessive thirst	NO	YES
Dry skin	NO	YES
Excessive urination	NO	YES

BLOOD

Slow healing after cut	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES
HIV/AIDS	NO	YES
Past transfusion	NO	YES

HISTORY QUESTIONNAIRE

PATIENT: _____
DOB: _____
DATE: _____

PLEASE LIST ALL MEDICATIONS & SUPPLEMENTS YOU ARE TAKING:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Medical History	Have you ever had:		<u>Year Diagnosed</u>
Diabetes	NO	YES	
High blood pressure	NO	YES	
Heart disease	NO	YES	
Lung disease	NO	YES	
Cataracts	NO	YES	
Glaucoma	NO	YES	
Retinal Problems	NO	YES	
Hepatitis	NO	YES	
Vascular Disease	NO	YES	
Cancer	NO	YES	IF YES, location of cancer:

Family History	Any Blood Relative had:		(If so, whom)
Diabetes	NO	YES	
High blood pressure	NO	YES	
Heart disease	NO	YES	
Lung disease	NO	YES	
Cataracts	NO	YES	
Glaucoma	NO	YES	
Retinal Problems	NO	YES	
Hepatitis	NO	YES	
Vascular Disease	NO	YES	
Cancer	NO	YES	IF YES, location of cancer:

PLEASE LIST ANY PREVIOUS SURGERIES YOU HAVE HAD:

PATIENT SOCIAL HISTORY:

Use of alcohol Never Rarely Moderate Daily
Use of tobacco Never Previous, but quit Daily
Year you began using tobacco _____ Year you stopped using tobacco _____
Use of drugs Never Type/frequency:
Excessive exposure at home or work to: Fumes Dust Solvents Noise