PATIENT HISTORY - REVIEW OF SYSTEMS

PATIENT NAME: | **HEIGHT & WEIGHT:** | **DATE:**

REVIEW OF SYSTEMS

	YES	NO
01. CONSTITUTIONAL		
Fever	☐	☐
Weight Loss	☐	☐
Feeling Sick	☐	☐
02. EYES:		
Injuries	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
03. CARDIOVASCULAR:		
BP over 130/90	☐	☐
Chest Pain	☐	☐
Irregular Heart Beats	☐	☐
Poor Blood Circulation	☐	☐
04. ENT:		
Complete Hearing Loss	☐	☐
Ringing in Ears	☐	☐
Recent Hearing Loss	☐	☐
05. RESPIRATORY		
Wheezing	☐	☐
Shortness of Breath	☐	☐
Cough	☐	☐
06. GASTROINTESTINAL:		
Rectal Bleeding	☐	☐
Abdominal Bleeding	☐	☐
Black Tar-like Stools	☐	☐
07. URINARY:		
Painful with Urination	☐	☐
Involuntary Urination	☐	☐
Decreased Urinary Flow	☐	☐
08. MUSCULOSKELETAL:		
Locking in Joints	☐	☐
Popping in Joints	☐	☐
Swelling in Joints	☐	☐
09. INTEGUMENTARY:		
Skin Rash	☐	☐
Skin Lumps	☐	☐
Wounds on Skin	☐	☐
Abrasions	☐	☐
10. NEUROLOGICAL:		
Burning Sensation	☐	☐
Tingling	☐	☐
Loss of Bowell/Bladder	☐	☐
Sensation Loss	☐	☐
11. PSYCHIATRIC:		
Depressed Feeling	☐	☐
Suicide Attempts	☐	☐
Hallucinations:	☐	☐
12. ENDOCRINE:		
Excessive Thirst	☐	☐
Changes in Hair	☐	☐
Decreased Energy	☐	☐
13. HEMATOLOGIC		
Bleed Easily	☐	☐
Fatigue Easily	☐	☐
Bruise Easily	☐	☐
14. IMMUNOLOGIC:		
Skin Reactions	☐	☐
Swelling in an Area	☐	☐
Anaphylaxis	☐	☐

ALLERGIES to medications & reactions or NONE ☐ ☐

Please list:

MEDICATION(S) currently taking or NONE ☐ ☐

PAST MEDICAL HISTORY:

ILLNESSES	YES	NO
Arthritis (type)	☐	☐
Asthma or bronchitis	☐	☐
Bladder Infection	☐	☐
Blood Clots (DVT)	☐	☐
Blood Disorders	☐	☐
BLOOD THINNERS	☐	☐
Cancer (type)	☐	☐
Deep Venous Thrombosis	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Gastritis (GERD)	☐	☐
GI Bleeding	☐	☐
Gout	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
HIV / AIDS	☐	☐
Hypertension (BP > 130/90)	☐	☐
Kidney Stones	☐	☐
Liver Disease / Hepatitis	☐	☐
Lung Disease	☐	☐
Lyme Disease	☐	☐
Neurological Disease	☐	☐
Osteoporosis	☐	☐
PACEMAKER	☐	☐
Parkinson's Disease	☐	☐
Prostate Enlargement	☐	☐
Pulmonary Em-bolus	☐	☐
Stomach Ulcers	☐	☐
Strokes / Seizures	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐

OTHER:

FRACTURES – NON-HOSPITILIZED:

PAST SURGERIES:	YES	NO
Appendix	☐	☐
Arthroscopic	☐	☐
Breast Biopsy	☐	☐
Cancer (type)	☐	☐
Coronary Artery	☐	☐
Bypass / Stent	# _____	
Gallbladder	☐	☐
Hysterectomy	☐	☐
Joint Replacement	☐	☐
Prostate	☐	☐
Spine – back / neck	☐	☐
Tonsils	☐	☐
Wisdom Teeth	☐	☐

OTHER HOSPITALIZATIONS:

SOCIAL HISTORY:

Married _____ Single _____

Divorced _____ Widowed _____

PREGNANCIES:

Number of pregnancies _____

Number of children living _____

HOUSEHOLD STATUS:

Number in household _____

SMOKING USAGE:

Current: _____packs a day

# of years smoking: _____

Stopped smoking date: _____

# of years _____ # packs a day ____

Never Smoked: _____

ALCOHOL USAGE:

Current: _____drinks a day

Social drinking only _____

Never drank _____

ILLICIT DRUG USAGE:

Currently Using _____

Total # years _____

Never used _____

FAMILY HISTORY:	YES	NO
Alcoholism	☐	☐
AIDS	☐	☐
Bleeding Disorder	☐	☐
Cancer (type)	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Malignant Hyperthermia	☐	☐
Mental Illness	☐	☐

OTHER:

Can you walk a mile? ☐ ☐

Can you climb a flight of stairs? ☐ ☐

Have you had a mammogram or breast MRI?

No ____If yes, when _____

Have you had a colonoscopy?

No ____If yes, when _____

Jul-13