

PAST MEDICAL HISTORY

PLEASE CHECK THE APPROPRIATE BOX

	YES	NO		YES	NO
Anemia _____	↑	↑	HSV _____	↑	↑
Asthma _____	↑	↑	Hypertension _____	↑	↑
Boils _____	↑	↑	Nephritis _____	↑	↑
Cancer/Tumors _____	↑	↑	PUD _____	↑	↑
Chickenpox _____	↑	↑	Rubella _____	↑	↑
COPD _____	↑	↑	Rubeola _____	↑	↑
Diabetes _____	↑	↑	Thyroid Disorder _____	↑	↑
Eczema _____	↑	↑	Tonsillitis _____	↑	↑
Hay fever _____	↑	↑	Tuberculosis _____	↑	↑
Heart Disease _____	↑	↑	Varicella Zoster Virus _____	↑	↑
Hepatitis _____	↑	↑			

PAST SURGICAL HISTORY

PLEASE CHECK THE APPROPRIATE BOX

	YES	NO		YES	NO
Abdominal Surgery _____	↑	↑	Foot Surgery _____	↑	↑
Appendectomy _____	↑	↑	Ganglion Cyst Removal _____	↑	↑
Back Surgery _____	↑	↑	Gastric Bypass _____	↑	↑
Biopsy _____	↑	↑	Hemorrhoidectomy _____	↑	↑
Bladder Suspension _____	↑	↑	Hernia Repair _____	↑	↑
Brain Surgery _____	↑	↑	Hip Replacement (left) _____	↑	↑
Breast Implant/Enhancement _____	↑	↑	Hip Replacement (right) _____	↑	↑
Breast Reconstruction _____	↑	↑	Hysterectomy _____	↑	↑
Breast Reduction _____	↑	↑	Knee Surgery (left) _____	↑	↑
Breast Surgery _____	↑	↑	Knee Surgery (right) _____	↑	↑
Breast Tumor Removal _____	↑	↑	Laparoscopy _____	↑	↑
Cervix Surgery/Procedure _____	↑	↑	Liposuction _____	↑	↑
Colonoscopy _____	↑	↑	Lumpectomy _____	↑	↑
C-Section _____	↑	↑	Removal /Kidney Stones _____	↑	↑
Cyst Removal _____	↑	↑	Tonsillectomy _____	↑	↑
D and C _____	↑	↑	Tubal Ligation _____	↑	↑
Eye Surgery _____	↑	↑	Vasectomy _____	↑	↑

(Over please)

FAMILY HISTORY

PLEASE FILL IN ALL APPLICABLE CONDITIONS

<u>DISORDER</u>	YES	NO	<u>APPLICABLE FAMILY MEMBER</u>
Cancer	↑	↑	_____
Colon Polyps	↑	↑	_____
Crohn's Disease	↑	↑	_____
Diabetes, Insulin dependent	↑	↑	_____
Diabetes, Non-Insulin dependent	↑	↑	_____
Diabetic Retinopathy	↑	↑	_____
Grave's Disease	↑	↑	_____
Hay Fever	↑	↑	_____
Heart Disease	↑	↑	_____
Heart Problems	↑	↑	_____
Hypertension	↑	↑	_____
Kidney Disease	↑	↑	_____
Leukemia	↑	↑	_____
Lupus	↑	↑	_____
Ovarian Cancer	↑	↑	_____
Peptic Ulcer	↑	↑	_____
Sickle Cell Disease	↑	↑	_____
Stomach Ulcer		↑↑	_____
Stroke	↑	↑	_____
Thyroid Disease	↑	↑	_____
Tuberculosis	↑	↑	_____
Uterine Fibroids	↑	↑	_____
Vaginal Cancer	↑	↑	_____
Vitiligo	↑	↑	_____
Warts	↑	↑	_____

SOCIAL HISTORY

PLEASE CHECK THE APPROPRIATE BOX

	YES	NO
Alcohol use _____	↑	↑
Illegal Drug use _____	↑	↑
Tobacco use _____	↑	↑

NAME _____

DATE _____

REVIEW OF SYSTEMS

PLEASE CHECK THE APPROPRIATE BOX

YES NO

- | | | |
|--|---|--------|
| Constitutional symptoms such as;
fever, headache, nausea, dizziness _____ | ↑ | ↑ |
| Urinary symptoms _____ | ↑ | ↑ |
| Skin-related symptoms _____ | ↑ | ↑ |
| Anemia _____ | ↑ | ↑ |
| Loss of feeling _____ | ↑ | ↑ |
| Ankle swelling _____ | ↑ | ↑ |
| Joint discomfort _____ | ↑ | ↑ |
| Asthma attack recently _____ | ↑ | ↑ |
| Blisters in mouth _____ | ↑ | ↑ |
| Burning _____ | ↑ | ↑ |
| Burning sensation in mouth _____ | ↑ | ↑ |
| Change in color of fingers/toes _____ | ↑ | ↑ |
| Cough, with mucous _____ | | ↑ ↑ |
| Depression _____ | | ↑ ↑ |
| Difficulty in swallowing _____ | ↑ | ↑ |
| Dry hair _____ | ↑ | ↑ |
| Dry, scaly skin _____ | ↑ | ↑ |
| Difficulty breathing _____ | | ↑ ↑ |
| Difficulty urinating _____ | ↑ | ↑ |
| Excess hair growth _____ | ↑ | ↑ |
| Eyes watering _____ | ↑ | ↑ |
| Facial swelling _____ | ↑ | ↑ |
| Hyperhidrosis _____ | ↑ | ↑ |
| Itchy eyes _____ | ↑ | ↑ |
| Night sweats _____ | ↑ | ↑ |
| Recent hair loss _____ | ↑ | ↑ |
| Seasonal allergies _____ | ↑ | ↑ |
| Thyroid disease _____ | ↑ | ↑ |
| Weight gain _____ | ↑ | ↑ |
| Weight loss, intentional _____ | ↑ | ↑ |
| Weight loss, unintentional _____ | ↑ | ↑ |
| White patches in mouth _____ | ↑ | ↑ |

