

PAST MEDICAL HISTORY

PLEASE CHECK THE APPROPRIATE BOX

YES	NO	YES	NO
Anemia _____		HSV _____ <input type="checkbox"/>	<input type="checkbox"/>
Asthma _____		Hypertension _____ <input type="checkbox"/>	<input type="checkbox"/>
Boils _____		Nephritis _____ <input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumors _____		PUD _____ <input type="checkbox"/>	<input type="checkbox"/>
Chickenpox _____		Rubella _____ <input type="checkbox"/>	<input type="checkbox"/>
COPD _____		Rubeola _____ <input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____		Thyroid Disorder _____ <input type="checkbox"/>	<input type="checkbox"/>
Eczema _____		Tonsillitis _____ <input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____		Tuberculosis _____ <input type="checkbox"/>	<input type="checkbox"/>
Heart Disease _____		Varicella Zoster Virus <input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
Illegal Drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use _____	<input type="checkbox"/>	<input type="checkbox"/>

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 _____