



**REVIEW OF MEDICAL SYSTEMS - PATIENT:** \_\_\_\_\_

Circle YES or NO if you have current problems – If Yes:  Check any specific symptoms

- Nose:** Yes / No  
 Loss of Smell  
 Itching/allergies  
 Sinus pain  
 Nose bleeds

- Ears:** Yes / No  
 Ringing  
 Hearing loss  
 Infection

- Mouth:** Yes / No  
 Ulcers/sores  
 Jaw cramping  
 Chewing pain  
 Painful to talk  
 Tooth infection  
 Hard to swallow

- Cardio-vascular:** Yes / No  
 Chest pain at rest  
 Chest pain on exertion  
 Faintness  
 Poor circulation  
 Heartbeat skips  
 Murmur  
 High cholesterol  
 Blood disorder  
 Bleeding disorder  
 Clotting problem

- Respiratory:** Yes / No  
 Breath shortness  
 Unable to breathe lying down  
 Chest pressure  
 Productive cough  
 Bloody spit  
 TB Exposure

- Gastro-intestinal:** Yes / No  
 Diarrhea  
 Abdominal pain  
 Nausea/vomiting  
 Fullness  
 Mass  
 Blood in stool  
 Jaundice  
 Liver problems

- Genitourinary:** Yes / No  
 Sores/ulcers  
 Discharge  
 Urination:  
 Painful  
 Difficult  
 Increased  
 Sexually transmitted  
disease: \_\_\_\_\_  
 Kidney failure  
 Kidney disease  
 Premature birth of children  
 Miscarriages

- Musculoskeletal:** Yes / No  
 Neck stiffness/pain  
 Lower back stiffness/pain  
 Joint pain  
 Joint swelling  
 Osteoporosis  
 Shoulder Ache  
 Hip ache  
 Arthritis:  
Specify: \_\_\_\_\_  
 Hand increase  
 Head/hat size increase

- Skin/hair/nails:** Yes / No  
 Skin rash  
 Skin color change  
 Hair increase  
 Nail changes  
 Skin ulcers  
 Tender nodes

- Neurological:** Yes / No  
 Numbness  
 Weakness  
 Seizures  
 Memory loss  
 Unconsciousness  
 Headaches  
 Head Trauma  
 Tender Scalp  
 Claustrophobia

- Endocrine:** Yes / No  
 Palpitations  
 Increased thirst  
 Weight loss  
 Loss of appetite  
 Night sweats  
 Chills  
 Fatigue  
 Fever

- Lymphatic:** Yes / No  
 Tender nodes  
 Swollen nodes  
 Hepatitis

- Psychiatric:** Yes / No  
 Difficult sleep  
 Feel sad/blue  
 Threatened  
 Abused/hurt  
 Alzheimers

- Allergic:** Yes / No  
 Itching  
 Sneezing  
 Watering eyes

- Known allergies:**  
 Penicillin  
 Codeine  
 Sulfa drugs  
Other allergies:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

### FAMILY HISTORY

	Age:	Living:	Medical problems or Cause of Death:
Mother:	_____	Y N	_____
Father:	_____	Y N	_____
Siblings	_____	Y N	_____
	_____	Y N	_____

Please check the box for each condition that applies to your relative and indicate the relationship:  
F: Father M: Mother S: Sister B: Brother GP: Grandparents C: Children O: Aunts/Uncles

Check:	Relative:	Check:	Relative:
_____ Glaucoma:	_____	_____ Diabetes:	_____
_____ Macular Degeneration	_____	_____ Cancer:	_____
_____ Retinal detachment	_____	_____ Heart Disease	_____
_____ Retinitis Pigmentosa	_____		

### SOCIAL HISTORY

Please Circle the correct answer:

Do you drive? YES or NO  
Do you drive at night? YES or NO  
Do you have pets or animal exposure? YES or NO  
If YES, what type of animals? \_\_\_\_\_

Do you use tobacco products? YES or NO  
If YES, Type and frequency: \_\_\_\_\_  
Call 1-800-QUITNOW for free help and information on stopping tobacco.

Do you drink alcohol beverages? YES or NO  
If YES, how frequently? Drinks/day? \_\_\_\_\_

Do you use any recreational drugs? YES or NO  
If YES, Type of drugs and frequency: \_\_\_\_\_

Do you eat undercooked meat or fish? YES or NO

**Patient name:** \_\_\_\_\_

**OCCUPATIONAL HISTORY**

**Are you currently employed?    YES    or    NO**

**Current Employer:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**What is/was your occupation?** \_\_\_\_\_

**Do you feel safe at home?            YES    or    NO**

**Are you in a relationship in which you are being hurt or threatened emotionally or physically?  
Call the Domestic Abuse Hotline 1-800-500-1119 for help.**

**I have completed this medical history to the best of my ability:**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_