

Patient History and Review of Systems (18 years and older)

Name: _____ Date: _____

Check if you have the following:

GENERAL

- Fever
- Chills
- Sweats
- Anorexia
- Fatigue
- Weakness
- Malaise
- Weight Loss
- Sleep Disorder

EYES

- Vision Loss-1 Eye
- Double Vision
- Eye Irritation
- Vision Loss-Both Eyes
- Blurring
- Eye Pain
- Halos
- Eye Discharge
- Light Sensitivity

EARS, NOSE AND THROAT

- Ringing in Ears
- Ear Discharge
- Earache
- Decreased Hearing
- Nasal Congestion
- Nosebleeds
- Difficulty Swallowing
- Hoarseness
- Sore Throat

CARDIOVASCULAR

- Diff. Breathing at Night
- Near Fainting
- Chest Pain or Discomfort
- Racing/Skipping Heart Beats
- Fatigue
- Lightheadedness
- Shortness of Breath with Exertion
- Palpitations
- Swelling of Hands or Feet
- Difficulty Breathing Lying Down
- Fainting
- Leg Cramps with Exertion
- Bluish Color Lips/Nails
- Weight Gain

RESPIRATORY

- Breathing Disturbs Sleep
- Cough
- Shortness of Breath
- Coughing up Blood
- Chest Discomfort
- Wheezing
- Excessive Sputum
- Excessive Snoring

GASTROINTESTINAL

- Excessive Appetite
- Loss of Appetite
- Indigestion
- Vomiting Blood
- Nausea
- Vomiting
- Yellow Skin Color
- Gas
- Abdominal Pain
- Abdominal Bloating
- Hemorrhoids
- Diarrhea
- Change in Bowel Habits
- Constipation
- Dark, Tarry Stools
- Blood in the Stools

GENITOURINARY

- Foul Urinary Discharge
- Blood in Urine
- Urinary Frequency
- Inability to Empty Bladder
- Urinary Urgency
- Kidney Pain
- Trouble Starting Stream
- Painful Urination
- Nighttime Urination
- Inability to Control Bladder
- Genital Sores
- Lack of Sexual Drive
- Erectile Dysfunction
- Excessively Heavy Periods
- Missed Periods
- Unusual Urinary Color
- Abnormal Vaginal Bleeding
- Pelvic Pain

MUSCULOSKELETAL

- Muscle Cramps
- Joint Pain
- Joint Swelling
- Joint Fluid Present
- Back Pain
- Stiffness
- Muscle Weakness
- Arthritis
- Gout
- Loss of Strength
- Muscle Aches

DERMATOLOGICAL

- Excessive Perspiration
- Night Sweats
- Suspicious Lesions
- Changes in Nail beds
- Dryness
- Poor Wound Healing
- Unusual Hair Distribution
- Skin Cancer
- Itching
- Changes in Skin Color
- Flushing
- Rash

NEUROLOGICAL

- Diff. with Concentration
- Poor Balance
- Headaches
- Coordination Difficulty
- Numbness
- Inability to Speak
- Falling Down
- Tingling
- Brief Paralysis
- Visual Disturbance
- Seizures
- Weakness
- Sensation of Room Spinning
- Tremors
- Fainting
- Excessive Daytime Sleepiness
- Memory Loss

PSYCHOLOGICAL

- Sense of Great Danger
- Anxiety
- Thoughts of Suicide
- Mental Problems
- Depression
- Thoughts of Violence
- Frightening Visions/Sounds

ENDOCRINE

- Excessive Hunger
- Cold Intolerance
- Heat Intolerance
- Excessive Urination
- Excessive Thirst
- Weight Change

HEMATOLOGY

- Enlarged Lymph Nodes
- Bleeding
- Skin Discoloration
- Abnormal Bruising
- Fevers

ALLERGY

- Persistent Infections
- Hives or Rash
- Seasonal Allergies
- HIV Exposure

BREAST

- Left Breast Lump
- Right Breast Lump
- Nipple Discharge
- Bloody Discharge from Nipple
- Breast Pain
- Abnormal Mammogram
- Breast Enlargement

**...CONTINUED ON
OTHER SIDE....**

Women Only:

1. Age first period _____
2. Age of menopause _____
3. Date of last period _____
4. Pelvic or vaginal infection _____
5. Contraception used _____
6. # of Pregnancies: _____
 Miscarriage _____ Abortion _____
7. Last Mammogram _____
8. Mammogram Result _____
9. Last Pap _____ Result _____
10. Last Colonoscopy _____ Result _____

Men Only:

1. Prostate Concerns or Trouble _____
2. Last Colonoscopy _____ Result _____

Medical Conditions: _____ Date _____

Bring list of medication or note below

Medications _____ Dose _____

Allergies

Surgeries & Hospitalizations: _____ Date _____

Family History:

Who:

1. Alcoholism _____
2. Anemia _____
3. Arthritis _____
4. Anesthetic Complications _____
5. Anxiety _____
6. Asthma _____
7. Birth Defects _____
8. Blood Clots _____
9. Blood Transfusions _____
10. Breast Cancer _____
11. Cervical Cancer _____
12. Colon Cancer _____
13. Depression _____
14. Diabetes _____
15. Growth/Development _____
16. Heart Disease _____
17. Angina _____
18. Hypertension _____
19. High Cholesterol _____
20. Psychiatric Care _____
21. Osteoporosis _____
22. Seizures _____
23. Severe Allergies _____
24. Stroke _____
25. Suicide Attempt _____
26. Bowel Disease _____
27. Heart Attack _____
28. Kidney Disease _____
29. Respiratory Disease _____
30. Liver Disease _____
31. Sexually Transmitted Disease _____
32. Ulcers _____
33. Other Diseases _____
34. Coronary Heart Disease male<55 _____
35. Coronary Heart Disease Female<65 _____
36. Colon Cancer-Father _____
37. Colon Cancer-Mother _____
38. Lung Disease _____
39. Melanoma _____
40. Ovarian Cancer _____
41. Uterine Cancer _____
42. Other Cancer _____
43. Thyroid Disease _____
44. Weight Disorder _____
45. Headaches _____
46. Other Medical Problems _____
47. PMS _____
48. Endometriosis _____

Risk Factors:

1. Ever Smoked?: yes no
 Packs per day _____ Year Started _____
 Date Quit _____
2. Does anyone smoke in your home? _____
3. Drug Use _____
4. Alcohol Use; # of Drinks per Day _____
5. Exercise: Frequency/week _____
 Type _____
6. Date of last Tetanus Shot _____
7. Date of last Pneumovax Shot _____