

Patient Name _____

MEDICAL HISTORY (Cont.)

Review of systems:

Are you currently experiencing problems with any of the following?

If yes, please explain

Sudden weight gain or loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Chronic fever or chronic fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Heart (example: chest pain, angina, irregular heart beat)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Respiratory (example: coughing, wheezing, shortness of breath, asthma)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ear/Nose/Throat (example: sore throat, sinus problem, earache, hearing loss)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gastrointestinal (example: abdominal pain, heartburn, bowel problems, vomiting)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Urinary (example: pain when urinating, blood in urine)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Hematologic/Lymphatic (example: blood disorders, bruising, cuts heal slowly, enlarged glands)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Endocrine (example: thyroid problems)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Integumentary (example: rashes, dry skin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Musculoskeletal (example: joint pain, stiffness or swelling, muscle pain or weakness)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Neurological (example: numbness, headache, seizures, paralysis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Psychiatric (example: depression, anxiety, insomnia, confusion)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Allergic/Immunologic (example: reaction to food or drugs, allergies, hay fever)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Social History:

Use of alcohol Never Rarely Moderate Daily

Use of tobacco Never Previously, but not in past _____ years Yes _____ packs/day

Family Medical History:

	Age	Eye Disease
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Children	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of patient (or guardian, if minor)

Date

Physician's signature

Date