



**PAST MEDICAL HISTORY:****Previous Surgeries & Chronic Conditions**

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**HABITS/SOCIAL HISTORY: Please Circle**

- Do you follow a special diet? YES NO
- Do you use caffeine? YES NO  
a. Amount/day? \_\_\_\_\_
- Do you use alcohol? YES NO  
a. Amount/day? \_\_\_\_\_
- Do you have a history of drug use/abuse? YES NO
- Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

**REVIEW OF SYSTEMS: Please Circle****A. GENERAL**

- Do you tire easily? YES NO  
When did you first notice? \_\_\_\_\_
- Have you had a recent fever, chills or sweats? YES NO
- Skin rashes? YES NO
- Have you had a recent weight loss/gain? YES NO  
Amount \_\_\_\_\_

**B. EYES**

- Have you ever had
- Blurry vision YES NO
  - Glaucoma YES NO
  - Partial or total loss of vision/lenses YES NO
  - Cataracts YES NO

**C. THROAT, MOUTH, AND EARS**

- Do you have any problems with
- nose YES NO
  - sinus YES NO
  - mouth/teeth YES NO
  - throat YES NO
  - hearing/ears YES NO
- Comment: \_\_\_\_\_

**D. RESPIRATORY**

- Have you had
- Asthma or wheezing? YES NO
  - Emphysema or bronchitis? YES NO
  - Chronic cough? YES NO
  - Bloody sputum? YES NO
  - Do you snore loudly? YES NO
  - Do you wake up more than once a night? YES NO
  - Are you tired first thing in the AM? YES NO

**E. GASTROINTESTINAL**

- Do you have
- Heartburn YES NO
  - Sour regurgitation/acid reflux YES NO
  - Difficulty swallowing YES NO
  - Hiatal hernia YES NO
  - Stomach ulcer YES NO
  - Rectal bleeding/black or bloody stools YES NO
  - Gall bladder problems YES NO
  - Recent change in bowel habits YES NO
  - Liver disease/Hepatitis YES NO

**F. GENITO-URINARY TRACT**

- Do you have
- Blood in urine YES NO
  - Problems with urination YES NO
  - Urinary Infections YES NO
  - Kidney/Bladder Stones YES NO
  - Kidney failure/Dialysis YES NO
  - Do you have nighttime urination? YES NO  
How often? \_\_\_\_\_
  - Impotence YES NO
  - Menopause YES NO
  - Hysterectomy YES NO

**G. MUSCULOSKELETAL**

- Have you had
- Arthritis YES NO
  - Gout YES NO
  - Muscle or Joint Pains YES NO

**H. ENDOCRINE**

- Have you had thyroid problems? YES NO
- Diabetes? YES NO

**I. HEMATOLOGY/LYMPHATIC**

- Have you had
- Anemia YES NO
  - Bruise/bleed easily YES NO
  - Cancer YES NO  
Where? \_\_\_\_\_

**J. NEUROLOGIC**

- Have you had
- Chronic Headaches YES NO
  - Dizziness/lightheadedness YES NO
  - Fainting YES NO
  - Stroke YES NO
  - Seizure disorder YES NO
  - Numbness/tingling YES NO

**K. PSYCHIATRIC**

- Do you have a history of mental illness? YES NO
- Do you have feelings of depression? YES NO
- Do you have an anxiety problem? YES NO

**PHYSICAL EXAMINATION**

General: development distress mood/affect skin  
VITALS:

ENT: xanthelasma oral mucosa

NECK: carotids JVD thyroid

CHEST: respirations lungs AP diameter

HEART: rhythm gallop/murmur palpation

ABD: soft tenderness organomegaly bruits bowel sounds

RECTAL/PELVIC:

EXTREM: clubbing/cyanosis pulses  
edema vs rales bruits

NEURO: IOC, grasp, reflexes, focal deficits