

**HISTORY AND
REVIEW OF SYSTEMS**

FRONT

Name: _____ DOB: ____ / ____ / ____ Today's Date: _____

Primary Care Physician: _____ Referring Physician: _____

What are we seeing you for today? _____

How long have you had this problem? _____ Telephone or location of your pharmacy: _____

CURRENT MEDICAL HISTORY: Please check (✓) all that apply:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Hiatal Hernia/GERD | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Implanted Device | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer: TYPE _____ | <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Sugar | |

ALLERGIES: List all medication and/or food allergies and the type of reaction (Ex: Sulfa-rash, Codeine-nausea, etc.)

Allergy:	Type of reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Are you allergic to latex? Yes No

Circle any of the following that you are currently taking on a regular basis:

Aspirin Arthritis medication Xarelto Eloquis Coumadin/Warfarin Other blood thinner

CURRENT MEDICATIONS: List all medications:

Medicine	Over-the-Counter Vitamins and Supplements	Dosage	How Often?	Provider
EX: Lasix		20 mg	Twice a day	Dr. Jones
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SURGICAL HISTORY:

Appendectomy – Date: _____	Endoscopy – Date: _____
Back/Neck – Date: _____	Gallbladder – Date: _____
Bariatric – Date: _____	Hernia Repair – Date: _____
Breast – Date: _____	Hysterectomy – Date: _____
Cardiac – Date: _____	Reflux – Date: _____
Colon – Date: _____	Thyroid – Date: _____
Colonoscopy – Date: _____	Other abdominal surgery: – Date: _____

**HISTORY AND
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BACK

FAMILY HISTORY: Please check &/or list all family members that apply

Illness:	Relation to you (circle)					Alive	Deceased
Brain Aneurysm	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	Mother	Father	Sibling	Child	Other	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY: Check &/or list all family members that apply:

Tobacco Use: Current / Former (Quit year _____) Never Exposure to smoke E-cigs Other: _____

Alcohol Use: Never drink Occasional drinker: _____ # drinks/day of alcohol

Drug Use: None Other use: _____

Caffeine Use: No Yes – how much: _____

Marital Status: Married Divorced Widowed Single Spouse's Name: _____
children _____ # grandchildren _____

REVIEW OF SYSTEMS: Check all that you are currently experiencing:

<p>General History:</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Increased Fatigue</p> <p><input type="checkbox"/> Trouble Sleeping</p> <p><input type="checkbox"/> Increased Appetite</p>	<p>Ear/Nose/Throat:</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Choking</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Ear Aches</p> <p><input type="checkbox"/> Sinus Drainage</p>	<p>Neurologic:</p> <p><input type="checkbox"/> Muscle Weakness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Memory Loss/Dementia</p>	<p>Vascular:</p> <p><input type="checkbox"/> Mini-Stroke/TIAs</p> <p><input type="checkbox"/> Pain in legs when walking</p> <p><input type="checkbox"/> Cramping in legs</p>
<p>Gastrointestinal:</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Regurgitation</p> <p><input type="checkbox"/> Difficulty Swallowing</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Early Feeling of Fullness</p> <p><input type="checkbox"/> Rectal Bleeding</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Change in Size/Color of stool</p> <p><input type="checkbox"/> # Bowel Movements/Day: _____</p>	<p>Breast (Female):</p> <p><input type="checkbox"/> Breast Mass</p> <p><input type="checkbox"/> Nipple Discharge: If yes, what color? _____</p> <p><input type="checkbox"/> Breast Pain/Tenderness</p> <p><input type="checkbox"/> Changes in Appearance</p> <p><input type="checkbox"/> Family History of Breast Cancer</p>	<p>OB/GYN (Female):</p> <p><input type="checkbox"/> Date of Last Period _____</p> <p><input type="checkbox"/> Age of Menstruation _____</p> <p><input type="checkbox"/> Menopause</p>	<p>Hematologic/Lymphatic:</p> <p><input type="checkbox"/> Slow to Heal After Cuts</p> <p><input type="checkbox"/> Easily Bruise or Bleed</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Past Transfusion</p> <p><input type="checkbox"/> Enlarged Glands</p>
<p>Respiratory:</p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Cough: <input type="checkbox"/> Mucous <input type="checkbox"/> Blood</p>	<p>Genitourinary:</p> <p><input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> Urinating Frequently at Night</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Loss of Bladder Control</p> <p><input type="checkbox"/> Weak Stream</p>	<p>Allergic/Immunologic:</p> <p><input type="checkbox"/> History of Skin Reaction To: _____</p> <p><input type="checkbox"/> Penicillin or Other Antibiotics</p> <p><input type="checkbox"/> Morphine or Other Narcotics</p> <p><input type="checkbox"/> Novocaine or Other Anesthetics</p> <p><input type="checkbox"/> Tetanus or Other Serums</p> <p><input type="checkbox"/> Iodine or Other Antiseptic</p> <p><input type="checkbox"/> Known Food Allergies _____</p>	
<p>Cardiac:</p> <p><input type="checkbox"/> Chest Pains</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Swollen Feet</p> <p><input type="checkbox"/> Shortness of Breath (when lying flat)</p> <p><input type="checkbox"/> Cardiac Cath: If yes, when: _____</p> <p><input type="checkbox"/> Cardiac Stress Test: If yes, when: _____</p>	<p>Endocrine:</p> <p><input type="checkbox"/> Glandular or Hormone Problem</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Excessive Thirst or Urination</p> <p><input type="checkbox"/> Heat or Cold Intolerance</p>		