MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Patient Name ______________________ Date ______________________

Date of Birth ______________________

Past Medical History: (Please circle all that apply)

Anemia	Gout
Anxiety	Blood or protein in the urine
Arthritis	Hearing problems
Asthma	Hepatitis
Auto Immune Disease	Hyperlipidemia
Bleeding problems/Blood clots	Hypertension
Coronary Artery Disease	Nephrolithiasis
Cancer	High Cholesterol
Heart Attack/Heart surgery	Osteoporosis
Heart cath/Heart failure	Neuromuscular Disease
Kidney Disease	Sleep Apnea/COPD
Depression	Stroke
Diabetes	Throid Problems
Eye Disorders/Cataracts	UTI/Recurrent
Gastrointestinal Disorders	Kidney Stones

Personal and Social History

Marital Status: (circle) Married Divorced Widowed Single

Occupation: ______________________________

Lives alone or with: ______________________________

Children: Y or N If Yes, Number of Sons ________
If Yes, Number of Daughters ________

Alcohol Use: Y or N
History of Drug Use: Y or N
Smoking Status: Smoker Never smoked Quit, if so when ________________

Diet: ______________________________
Exercise: ______________________________

Family History (Please circle all that apply) Indicate relative (mother, father, sibling, etc)

Heart Disease/Heart attack ______________________
Hypertension ______________________
Dyslipidemia ______________________
Diabetes ______________________
Anemia ______________________
Kidney Disease ______________________
Kidney Stones ______________________
Stokes ______________________
Cancer ______________________
Coronary Artery Disease ______________________
Other ______________________

Past Surgical History (Please list surgery and date)

Review of Symptoms (Please circle all that apply)

General:

Recent Weight loss	Fevers or sweats
Recent Weight gain	Chills
Fatigue	Other ______________
Feeling well in general	

Vision:

Yearly Eye Exams	Y or N
Damage from Diabetes	Y or N
Damage from Hypertension	Y or N

Head and Neck: (circle all that apply)

Sores in/around mouth	Sinus problems
change in hearing	

Cardiovascular: (circle all that apply)

Chronic cardiovascular disorders	Sudden loss of consciousness
Chest pain or pressure	Rapid or irregular heartbeat
Cholesterol problems	Leg pains or cramps
Orthopnea	Wounds/ulcers on feet
Lower extremity edema	Other ____________________

Pulmonary: (circle all that apply)

COPD/Asthma	Snoring or Stop breathing during sleep
Shortness of breath	Sleep Apnea
Cough	Other ____________________
Hemoptysis	

Gastrointestinal: (circle all that apply)

Chronic or past GI disorders	Vomiting blood
Heartburn	Black/tarry stools
Abdominal pain	Bloody stools
Difficulty swallowing	Constipation
Nausea or vomiting	Diarrhea
Jaundice	Other ____________________

Genito-Urinary: (circle all that apply)

Chronic or past GU disorders	Urine urgency
Blood in urine	Urine frequency
Buring with urination	Urine hesitancy
Urination at night	Other ____________________
Incontinence	

Musculoskeletal: (circle all that apply)

Known disorders	Joint redness
Joint pain	Low back pain
Muscle aches	Other ____________________
Joint swelling	

Skin and Hair: (circle all that apply)

Known diseases	Itching
Hair loss	Other ____________________
Skin eruptions or rashes	

Neurological: (circle all that apply)

Known disorders	Dizziness
Sudden loss of neurological function	Balance problems
Seizure activity	Headaches
Numbness	Tremors
Weakness	Other ______________________

Mental Health: (circle all that apply)

Known disorders	Other ______________________
Anxiety/depression	

Endocrine: (circle all that apply)

Known disorders	Fractures
Polyuria, polydypsia, polyphagia	History of low/high blood sugars
Throid problems	Other ______________________
Osteoporosis	

Hematology/Oncology: (circle all that apply)

Chronic or past disorders	Hypercoagubility
Anemia	Other ______________________
Abnormal bleeding/bruising	

Please List all Medications:

Name of Medication	Strength	Directions/How it is taken

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Medication Allergies: (List below)