

Patient Medical History & Review of Systems

Please indicate any personal history below, past or present

Where do you currently reside? Independently In an Assisted Living Facility In a Nursing Home

Constitutional Systems

- Recent weight changes No Yes
 loss / gain # of pounds _____
- Fever No Yes
- Eye disease or cataracts No Yes
- Wear glasses/contact lenses No Yes
- Blurred or double vision No Yes
- Glaucoma No Yes

Ears/Nose/Mouth/Throat

- Hearing loss or ringing No Yes
- Chronic sinus problems No Yes
- Nose bleeds No Yes
- Sore throat or voice change No Yes

Cardiovascular

- Heart murmur No Yes
- Mitral valve prolapse No Yes
- Rheumatic fever No Yes
- High or low blood pressure medication No Yes
- Chest pain or angina pectoris in last 30 days No Yes
- Palpitation No Yes
- Congestive Heart Failure No Yes
- Irregular pulse No Yes
- History of heart attack When? _____ No Yes
- Feet, ankle, or hand swelling No Yes
- Heart disease No Yes
- Coronary angiogram When? _____ No Yes
- Heart surgery When? _____ No Yes
- Peripheral Vascular Disease No Yes

Respiratory

- Chronic or frequent coughs No Yes
- Emphysema or COPD No Yes
- Asthma No Yes
- Bronchitis No Yes
- Tuberculosis or positive TB skin test No Yes
- Shortness of breath while walking or lying flat No Yes
- Wheezing No Yes
- Pneumonia No Yes
- Spitting up blood No Yes
- Sleep apnea No Yes

Gastrointestinal

- Abdominal pain No Yes
- Esophageal varices No Yes
- Nausea or vomiting No Yes
- Frequent diarrhea No Yes
- Change in bowel movement No Yes
- Painful bowel movements or constipation No Yes
- Rectal bleeding or blood in stool No Yes
- Stomach ulcer No Yes
- Vomiting blood No Yes
- History of liver disease No Yes
- Jaundice No Yes
- Hepatitis No Yes
- Ascites No Yes
- Hemorrhoids No Yes

Genitourinary

- Frequent urination No Yes
- Burning or painful urination No Yes
- Blood in urine No Yes
- Change in force of stream when urinating No Yes
- Incontinence or dribbling No Yes
- Kidney stones No Yes
- Male – testicle pain No Yes
- Date of last PSA _____
- Date of LMP _____
- Hysterectomy or Tubal ligation No Yes

Musculoskeletal

- Joint pain No Yes
- Muscle or joint weakness No Yes
- Muscle pain or cramps No Yes
- Back pain No Yes
- Cold extremities No Yes
- How far can you walk without pain? _____
- Pain while at rest No Yes
- Arthritis No Yes
- Hernia No Yes

Integumentary (skin, breast)

- Rash or itching No Yes
- Change in skin color No Yes
- Varicose veins No Yes
- Breast pain No Yes
- Breast lump No Yes
- Breast discharge No Yes
- Date of last mammogram _____

Psychiatric

- Memory loss or confusion No Yes
- Nervousness No Yes
- Depression No Yes
- Insomnia No Yes

Neurological

- Frequent/recurring headaches No Yes
- Light headed or dizzy No Yes
- Convulsions or seizures No Yes
- Numbness/tingling sensation No Yes
- Tremors No Yes
- Paralysis No Yes
- Head injury No Yes
- Stroke (RIND or TIA) No Yes
- Migraine headaches No Yes
- Brain tumor No Yes

Endocrine

- Prescription steroid use No Yes
- Glandular/hormone problems No Yes
- Excessive thirst or urination No Yes
- Heat or cold intolerance No Yes
- Diabetes No Yes
 oral medications or insulin
- Thyroid disease No Yes
- Kidney disease No Yes
- Kidney failure No Yes
- Hemo Dialysis or CAPD No Yes

Hematologic/Lymphatic

- Slow to heal after cuts No Yes
- Tendency to bleed or bruise No Yes
- Anemia No Yes
- Phlebitis or blood clots in legs No Yes
- Blood or plasma transfusion No Yes
- Enlarged glands No Yes
- Cancer No Yes
- Chemo or Radiation No Yes
- HIV + No Yes

Date & location of most recent bloodwork

Date & location of most recent EKG

Date & location of most recent chest X-ray

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

 Signature of patient (or parent if minor)

 Date

