

MEDICAL HISTORY: DETAILED REVIEW OF SYSTEMS
(PLEASE FILL OUT BOTH FRONT AND BACK OF THIS FORM)

NAME: _____ DOB _____ DATE: _____

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. Please check the appropriate answer after each question.

EYES, EARS, NOSE, AND THROAT:

- | | |
|---|------------|
| 1. Have there been changes in your vision? | Yes__ No__ |
| 2. Do you regularly have difficulty with hearing? | Yes__ No__ |
| 3. Do you experience ringing in your ears? | Yes__ No__ |
| 4. Do you experience Dizziness? | Yes__ No__ |
| 5. Do you experience frequent nosebleeds? | Yes__ No__ |
| 6. Do you experience sinus trouble? | Yes__ No__ |

NERVOUS SYSTEM, BONES, JOINTS, AND SKIN:

- | | |
|--|------------|
| 7. Do you suffer from frequent Migraine headaches? | Yes__ No__ |
| 8. Are you subjected to fainting or blackout spells? | Yes__ No__ |
| 9. Have you ever had a convulsion? | Yes__ No__ |
| 10. Have you ever been paralyzed? | Yes__ No__ |
| 11. Have you experienced numbness of fingers or feet? | Yes__ No__ |
| 12. Do you suffer from back pain? | Yes__ No__ |
| 13. Have you ever suffered from Rheumatism, Arthritis or Gout? | Yes__ No__ |
| 14. Do you suffer from rashes or itching of the skin? | Yes__ No__ |

HEART AND LUNGS:

- | | |
|---|------------|
| 15. Do you suffer persistent daily coughing? | Yes__ No__ |
| 16. Do you cough up phlegm or sputum? | Yes__ No__ |
| 17. Have you coughed up blood in the past year? | Yes__ No__ |
| 18. Do you suffer from frequent chest colds? | Yes__ No__ |
| 19. Have you had pneumonia or severe Bronchitis in the past? | Yes__ No__ |
| 20. Have you suffered from Asthma in the past? | Yes__ No__ |
| 21. Are you unusually short of breath when walking or working? | Yes__ No__ |
| 22. Have you ever been diagnosed with Emphysema of the lungs? | Yes__ No__ |
| 23. Do you experience chest pain? | Yes__ No__ |
| 24. Do you experience tightness of the chest when walking or working? | Yes__ No__ |
| 25. Do you often experience rapid heartbeat or thumping? | Yes__ No__ |
| 26. Do you experience swelling of the feet or legs by the end of the day? | Yes__ No__ |
| 27. Have you ever been diagnosed with having any heart problems? | Yes__ No__ |
| 28. Do you awaken during the night with shortness of breath? | Yes__ No__ |

STOMACH AND ABDOMEN:

- | | |
|---|------------|
| 29. Do you experience difficulty swallowing foods or liquids? | Yes__ No__ |
| 30. Are you often troubled by indigestion or heartburn? | Yes__ No__ |
| 31. Do you suffer from stomach problems? | Yes__ No__ |
| 32. Do you suffer from excessive gas or bloating? | Yes__ No__ |
| 33. Do you suffer with frequent vomiting? | Yes__ No__ |
| 34. Have you experienced any rectal bleeding? | Yes__ No__ |
| 35. Do you suffer from Constipation? | Yes__ No__ |
| 36. Do you frequently suffer from Diarrhea or Dysentery? | Yes__ No__ |

- 37. Do you suffer from itching around the rectum? Yes_ No_
- 38. Have you ever been diagnosed with stomach or duodenal ulcers? Yes_ No_
- 39. Have you ever been diagnosed with having Gallbladder problems? Yes_ No_
- 40. Have you ever been diagnosed with yellow Jaundice? Yes_ No_
- 41. Have you suffered with black stools? Yes_ No_

KIDNEY, BLADDER, AND MALE / FEMALE ORGANS:

- 42. Do you experience frequent urination during the night? Yes_ No_
- 43. Have you experienced painful or burning when urinating? Yes_ No_
- 44. Do you experience trouble urinating? Yes_ No_
- 45. Have you ever had blood in your urine? Yes_ No_
- 46. Do you experience difficulty emptying your bladder? Yes_ No_
- 47. Have you ever passed Kidney stones? Yes_ No_
- 48. Have you ever been treated for urine infections? Yes_ No_
- 49. Have you ever been diagnosed with any STD's? Yes_ No_

EMOTIONAL ISSUES / HABITS:

- 50. Do you suffer with fatigue? Yes_ No_
- 51. Do you suffer with frequent Insomnia? Yes_ No_
- 52. Do you suffer with nervousness or anxiety? Yes_ No_
- 53. Have you ever suffered a nervous breakdown? Yes_ No_
- 54. Do you suffer from Depression? Yes_ No_
- 55. Do you experience difficulties during intercourse? Yes_ No_
- 56. Do you drink Alcohol? (daily, weekly, monthly) Yes_ No_

GENERAL INFORMATION:

- 57. Do you experience large bruising of the skin? Yes_ No_
- 58. Do you bleed or hemorrhage excessively? Yes_ No_
- 59. Have you ever been treated for anemia? Yes_ No_
- 60. Have you experienced excessive weight gain? (more than 10 lbs.) Yes_ No_
- 61. Have you experienced frequent fevers in the past month? Yes_ No_
- 62. Do you suffer from excessive thirst? Yes_ No_
- 63. Have you ever been diagnosed with a Thyroid disorder? Yes_ No_

MEDICATIONS:

- 64. Do you have any allergies to medications? Yes_ No_

List medications and types of allergies:

- 65. Are you currently on any medication? Yes_ No_

List medications:

WOMEN ONLY:

- 66. Are your menstrual cycles regular / irregular? Yes_ No_
- 67. Have you missed any cycles in the last 6 months? Yes_ No_

*Are there any issues or concerns regarding your health that you would like the doctor be aware of?
