Patient Name: _____ Dob: _____ Visit Date: _____

MEDICAL HISTORY: DETAILED REVIEW OF SYSTEMS

(PLEASE FILL OUT BOTH FRONT AND BACK OF THIS FORM)

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__

Patient Name: _____ Dob: _____ Visit Date: _____

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 empting 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?

_____