

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Name _____ Age _____ Date of Birth _____

Primary Doctor _____ Date _____

Referring Doctor _____

Reason for Visit _____

Medications _____

Past Medical History

Surgeries _____

Illnesses - Please check all that apply

High Blood Pressure ___ Diabetes ___ High Cholesterol ___

Heart Disease ___ Stroke ___ Head Injury ___

Neck Injury ___ Back Injury ___ Migraine ___

Cancer ___ Epilepsy ___ Seizure ___

Asthma ___ Lung Disease ___ Peptic Ulcer ___

Psychiatric History ___ Other _____

Allergies _____

Family History _____

Social History

Smoking _____ Alcohol _____ Occupation _____

Marital Status _____

REVIEW OF SYSTEMS (circle all that apply)

1. **Constitutional** - none fever chills weight loss
2. **Eyes** - none double vision blurring pain spots
3. **Ears, Nose, Throat** - none ear pain discharge hearing loss ringing
nose pain discharge loss of smell throat pain hoarse voice trouble swallowing
4. **Cardiovascular** - none chest pain heart attack irregular heart beat
coronary artery disease
5. **Respiratory** - none asthma COPD cough sputum pneumonia
tuberculosis
6. **Gastrointestinal** - none nausea diarrhea constipation vomiting
blood in stool hepatitis
7. **Genitourinary** - none bladder infections frequent urination kidney stones
bloody urine
8. **Musculoskeletal** none joint pain joint swelling stiffness muscle pain
weakness
9. **Skin** - none rash lesions itching birthmarks cancer
10. **Neurological** - none headache migraine head trauma stroke TIA
numbness tingling weakness
11. **Endocrine** - none thyroid abnormality diabetes hot flashes irregular menses
12. **Hematologic** - none easy bruising bleeding anemia
13. **Allergy/Immunology** - none sneezing runny nose itching HIV
14. **Psychiatric** - none anxiety depression bipolar

If you are not the patient, print your name _____
Relationship _____

Date Updated _____ Reviewed by _____