



Date: \_\_\_\_\_

**CHIEF COMPLAINT/HISTORY OF ILLNESS:**

- 1. What is the reason for today's visit? \_\_\_\_\_
- 2. How long have you had this problem? \_\_\_\_\_
- 3. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10
Mild very severe
- 4. How often does this problem occur? [ ] constant [ ] comes and goes
- 5. What makes it better? \_\_\_\_\_
- 6. What makes it worse? \_\_\_\_\_
- 7. What other symptoms are you having? \_\_\_\_\_

**PAST MEDICAL HISTORY (Please check any illnesses you have):**

- [ ] High blood pressure [ ] Asthma/Emphysema [ ] Rheumatic fever Others: \_\_\_\_\_
- [ ] Kidney disease [ ] Stroke, mini-stroke [ ] Sinusitis \_\_\_\_\_
- [ ] Diabetes [ ] Heart disease/Angina [ ] Peptic ulcers \_\_\_\_\_
- [ ] Neck/Back disease [ ] Hepatitis/Liver disease [ ] Thyroid disease \_\_\_\_\_
- [ ] Cancer (please list type and date diagnosed): \_\_\_\_\_

**PAST SURGICAL HISTORY (Please check any surgeries you have had):**

- [ ] Heart bypass/valve [ ] Gall bladder [ ] Prostate removal Others: \_\_\_\_\_
- [ ] Coronary angioplasty [ ] Lung surgery [ ] Colon removal \_\_\_\_\_
- [ ] Carotid artery surgery [ ] Joint replacement [ ] Appendix removal \_\_\_\_\_
- [ ] Vascular bypass [ ] Back surgery [ ] Sinus surgery \_\_\_\_\_
- [ ] Mastectomy [ ] Brain surgery [ ] Tonsillectomy \_\_\_\_\_
- [ ] Heart transplant [ ] Liver transplant [ ] Kidney transplant \_\_\_\_\_

**MEDICATIONS (List all your current medications and the dose you take):**

- Medication \_\_\_\_\_ Dose \_\_\_\_\_
- Medication \_\_\_\_\_ Dose \_\_\_\_\_
- Medication \_\_\_\_\_ Dose \_\_\_\_\_
- Medication \_\_\_\_\_ Dose \_\_\_\_\_
- Do you take Aspirin or Ibuprofen? [ ] Yes [ ] No
- Do you take Warfarin (Coumadin)? [ ] Yes [ ] No
- Have you taken steroids within the past year? [ ] Yes [ ] No

**ALLERGIES (List medications/foods you are allergic to and what happens when you take them):**

- Medication \_\_\_\_\_ Reaction \_\_\_\_\_
- Medication \_\_\_\_\_ Reaction \_\_\_\_\_
- Medication \_\_\_\_\_ Reaction \_\_\_\_\_

**FAMILY HISTORY (Check all illnesses that run in your family):**

- [ ] Hearing loss [ ] Alcoholism [ ] Heart attack Others: \_\_\_\_\_
- [ ] High blood pressure [ ] Psychiatric illness [ ] Cancer \_\_\_\_\_
- [ ] Sickle cell anemia [ ] Bleeding problems [ ] Diabetes \_\_\_\_\_
- [ ] Poor circulation [ ] Anesthesia reaction [ ] Stroke \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Domestic partner  
How many children do you have? \_\_\_\_\_  
Have you ever smoked?  Yes  No ( cigarettes,  cigar,  pipe)  
How much, and for how long have you smoked? \_\_\_\_\_ packs per day for \_\_\_\_\_ years. Quit?  Yes  No When? \_\_\_\_\_  
How much alcohol do you drink each day? \_\_\_\_\_  
List any street drugs you currently use: \_\_\_\_\_  
Do you have any drug addictions?  Yes  No

**REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):**

**CONSTITUTIONAL**

Weight loss \_\_\_\_\_ pounds in the past \_\_\_\_\_ weeks  Fever, chills

**EYES:**

- Double vision
- Loss of vision
- Eye pain

**ENT:**

- Hearing loss
- Ringing in ears
- Dizziness
- Ear pain
- Ear drainage

- Nose drainage
- Nasal congestion
- Facial pain
- Headaches
- Sore mouth/throat

- Swallowing pain
- Voice change
- Snoring
- Hoarseness
- Poor sleep

**CARDIOVASCULAR/PULMONARY:**

- Chest pain
- Poor circulation
- Shortness of breath
- Heart attack
- Leg pain during walking
- Asthma
- Irregular heartbeat
- Coughing up blood

**GASTROINTESTINAL:**

- Stomach ulcers
- Blood in stool
- Nausea/vomiting
- Trouble swallowing
- Diarrhea
- Abdominal pain

**GENITOURINARY:**

- Blood in urine
- Pain during urination
- Difficulty making urine

**MUSCULOSKELETAL:**

- Neck/Spine surgery
- Neck or Back disorder
- Arthritis

**NEUROLOGICAL:**

- Stroke
- Loss of sensation
- Ministroke
- Paralysis of an arm or leg
- Temporary loss of vision or speech control
- Facial paralysis

**SKIN:**

- Skin cancers
- Allergy to medical tape, iodine, or latex

**PSYCHIARIC:**

- Clinical depression
- Hallucinations
- Schizophrenia
- Other psychiatric disorder (list) \_\_\_\_\_
- Anxiety

**INFECTIOUS DISEASE:**

- Hepatitis
- TB
- HIV/AIDS
- Mononucleosis

I have personally reviewed this history and review of systems:

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date