Patient History and Review of Systems

Name:_____ Date:_____

Past Medical History Please check all that apply:

☐ Diabetes ☐Controlled ☐Uncontrolled	☐ Chest Pain/Angina	☐ High Blood Pressure ☐Controlled ☐ Uncontrolled	☐ Heart Attack
☐ High Cholesterol	☐ Pacemaker	☐ Cancer	☐ Osteoporosis
☐ Blood Clots	☐ Asthma	☐ Stroke	☐ Seizures
☐ HIV/AIDS	☐ Hepatitis	☐ Stomach Ulcer	☐ Liver Disease
☐ Arthritis	☐ Heart Surgery	☐ Vascular Disease	☐ Tuberculosis
☐ Depression	☐ Congestive Heart Failure	☐ Thyroid Disease	☐ Kidney Disease

Are you allergic to any medications? ☐ NO ☐ Yes Please list:_____
Do you or a family member have a history of malignant hyperthermia? ☐ NO ☐ Yes
Have you or a family member ever had problems with anesthesia during surgery? ☐ NO ☐ Yes

Review of Systems Please check all that currently apply:

Constitutional	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue	☐ Sleep Apnea	☐ Insomnia
Eyes	☐ Blurry vision	☐ Eye pain	☐ Eye discharge	☐ Glaucoma	☐ Decreased vision	☐ Double vision
Ears,nose,throat	☐ Sore throat	☐ Ear pain	☐ Hearing loss	☐ Ear discharge	☐ Nose bleeds	☐ Ringing in ears
Cardiovascular	☐ Chest pain	☐ Palpitations	☐ Heart murmur	☐ Poor circulation	☐ Leg/feet swelling	☐ Rapid heart rate
Respiratory	☐ Shortness of breath	☐ Chronic cough	☐ Coughing blood	☐ Tuberculosis	☐ Excessive sputum production	
Gastrointestinal	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Bloody stool	☐ Trouble swallowing
Genitourinary	☐ Frequent urination	☐ Blood in urine	☐ Painful urination	☐ Incontinence	☐ Urinary retention	☐ Frequent UTI
Skin	☐ Rash	☐ Hives	☐ Hair loss	☐ Skin sores	☐ Itching	☐ Mole changes
Musculoskeletal	☐ Joint pain	☐ Muscle aches	☐ Frequent cramps	☐ Weakness	☐ Joint swelling	☐ Back pain
Psychiatric	☐ Anxiety	☐ Depression	☐ Panic attacks	☐ Suicidal thoughts	☐ Alcohol or drug dependence	
Endocrine	☐ Goiter	☐ Heat intolerance	☐ Cold intolerance	☐ Increased thirst	☐ Excess sweating	
Neurological	☐ Seizures	☐ Stroke	☐ Migraines	☐ Numbness	☐ Dizziness	☐ Slurred speech
Hem/Lymphatic	☐ Low blood count	☐ Chronic dialysis	☐ Transfusions	☐ Blood clots	☐ Swollen lymph nodes	☐ Prolonged bleeding
Allergic/Immun	☐ Allergic reactions	☐ Hay fever	☐ Frequent infections	☐ Hepatitis	☐ HIV positive	☐ Positive TB test

Social History

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoking History: ☐ Non-Smoker ☐ Ex-Smoker ☐ Current Smoker How many packs per day?_____
Alcohol Use: ☐ Never ☐ Occasional ☐ Frequent

Family History

Please list any known medical conditions
Father:_____ **Mother:**_____
Siblings:_____ **Your Children:**_____

Additional Information: *Use this space to provide information which may be important to your health care.*

_____ _____
Patient Signature Date Reviewing Physician Date