

Name: _____ Date of Birth: _____ Today's Date: _____

FAMILY HISTORY (Please describe below any illnesses found in the patient's blood relatives.)

Illness	Family Member(s)
Arthritis	
Diabetes	
Stroke	
Heart Disease	
Cancer	
Osteoporosis	
Bleeding Condition	
Scoliosis (curvature of the spine)	
Other Medical Problems	

MEDICAL AND SURGICAL HISTORY

➤ Please check ✓ all the boxes below that name the conditions that apply to you.

None Apply

Medical Problems			Recent Medical Tests
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Blood work
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Bone Scan
<input type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> CT scan
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> MRI
<input type="checkbox"/> Drug dependency	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Other:
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Previous Surgeries	Date	Hospital	Doctor
<input type="checkbox"/> No previous surgeries			
<input type="checkbox"/> Appendectomy			
<input type="checkbox"/> Cesarean Section			
<input type="checkbox"/> Gallbladder			
<input type="checkbox"/> Heart (open or bypass)			
<input type="checkbox"/> Joint surgery (arthroscopic or open) Which joint? _____			
<input type="checkbox"/> Hysterectomy			
<input type="checkbox"/> Spine surgery			
<input type="checkbox"/> Tonsillectomy			
<input type="checkbox"/> Other (please list) _____			

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REVIEW OF SYSTEMS

Have you recently had any of the following problems? Please check *all* boxes below that apply to you.

Problem		Yes	No	If yes, please explain
1. Constitutional (overall)	a. Weight gain			
	b. Weight loss			
	c. Fever or chills			
	d. Night sweats			
2. Eyes	a. Vision change			
3. Ears, Nose, Throat, Mouth	a. Difficulty hearing			
	b. Hoarseness			
4. Cardiovascular (heart)	a. Chest pain			
	b. Irregular heartbeat			
5. Respiratory (breathing)	a. Shortness of breath			
6. Gastrointestinal (digestion)	a. Stomach ulcers			
	b. Heartburn			
	c. Jaundice			
7. Genitourinary (urination)	a. Frequency			
	b. Painful urination			
8. Musculoskeletal (muscles & bones)	a. Joint pain			
	b. Night pain			
9. Skin and/or Breast	a. Rash or skin problems			
	b. Breast masses			
10. Neurological (nervous system)	a. Headaches			
	b. Numbness			
11. Psychiatric (emotions)	a. Mood changes			
12. Endocrine (hormones and glands)	a. Fatigue			
13. Hematologic (blood)	a. Anemia			
	b. Bleeding disorders			
	c. Blood transfusion			
14. Allergic	a. Pollens			
	b. Other:			
	c. Other:			

Additional Patient Comments: _____

Internal Use Only:

1. Reviewed by: _____ Date: _____ 3. Reviewed by: _____ Date: _____
 2. Reviewed by: _____ Date: _____ 4. Reviewed by: _____ Date: _____