

# Patient Health History and Systems Review

Name \_\_\_\_\_ Date \_\_\_\_\_

Major Accident or Falls: \_\_\_\_\_

Major Surgery/ Operations:  appendectomy  tonsillectomy  gall bladder  hernia  hysterectomy  
 broken bones  back surgery  c-section  epidural  pregnancy  other \_\_\_\_\_

Current Medications, including dosage if known. If there are no current medications, check here

1) _____	5) _____
2) _____	6) _____
3) _____	7) _____
4) _____	8) _____

List any known allergies you have had to any medications. If no allergies are known, check here

1) _____	3) _____
2) _____	4) _____

Check any of the following conditions or diseases you have had:

- |                                    |  |                                       |                                    |   |                                       |
|------------------------------------|--|---------------------------------------|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> heart disease | <input type="checkbox"/> lowback pain | <input type="checkbox"/> influenza | <input type="checkbox"/> mumps            | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anemia    | <input type="checkbox"/> chicken pox   | <input type="checkbox"/> pleurisy     | <input type="checkbox"/> thyroid   | <input type="checkbox"/> rheumatic fever  |                                       |
| <input type="checkbox"/> small pox | <input type="checkbox"/> diabetes      | <input type="checkbox"/> HIV          | <input type="checkbox"/> measles   | <input type="checkbox"/> whooping cough   |                                       |
| <input type="checkbox"/> cancer    | <input type="checkbox"/> epilepsy      | <input type="checkbox"/> eczema       | <input type="checkbox"/> polio     | <input type="checkbox"/> mental disorders |                                       |

System Review: Check any of the following you have had in the past 6 months

## General

- fatigue  loss of sleep  allergies  fever  headaches

## Gastro- Intestinal

- |   |  |  |   |  |   |
|---|--|--|---|--|---|
| <input type="checkbox"/> constipation     | <input type="checkbox"/> weight trouble          | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> hemorrhoids      | <input type="checkbox"/> nausea              | <input type="checkbox"/> heartburn                |
| <input type="checkbox"/> excessive thirst | <input type="checkbox"/> poor/excessive appetite | <input type="checkbox"/> gall bladder problems | <input type="checkbox"/> abdominal cramps | <input type="checkbox"/> black/ bloody stool | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> vomiting         | <input type="checkbox"/> colitis                 |  |   |  |   |

## Eye/ Ear/ Nose/ Throat

- vision problems  hearing difficulty  sore throat  ear aches  stuffy nose  dental prob.s

## Muscles/ Back/ Joints

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> foot problems     | <input type="checkbox"/> low back pain          | <input type="checkbox"/> neck pain        | <input type="checkbox"/> arm pain              | <input type="checkbox"/> arthritis                       |
| <input type="checkbox"/> general stiffness | <input type="checkbox"/> pain between shoulders | <input type="checkbox"/> walking problems | <input type="checkbox"/> joint pain/ stiffness | <input type="checkbox"/> difficult chewing/ clicking jaw |

**Cardio- Vascular**

- ankle swelling     short of breath     varicose veins     stroke     chest pain
- poor circulation     irregular heartbeat     lung problems/ congestion     heart trouble     blood pressure trouble

**Nervous System**

- nervous     paralysis     forgetfulness     fainting     cold/tingling extremities
- stress     dizziness     convulsions     numbness     confusion/ depression

**Genito- Urinary**

- bladder trouble     painful/excessive urination     discolored urine

**Male/ Female Specific:**

females only: date of last menstrual period \_\_\_\_\_ Are you pregnant?  yes  no

- breast pain/ lumps     prostate/sexual dysfunction     vaginal pain/ infection     menstrual irregularity     menstrual cramps     other problems

**Family History- The following members have a same or similar problem as I do:**

- mother     father     brother     sister     spouse     child

**Habits**    alcohol: \_\_\_\_\_ drinks/day    caffeine \_\_\_\_\_ cups/day

Do you currently smoke tobacco of any kind?  yes     former smoker     never been a smoker

*If yes, how often do you smoke:*  Current every day smoker     Current sometimes smoker

**Exercise**  none     light activity     moderate activity     active     very active     elite athlete

The above information was completed by the patient, reviewed with the patient by the doctor, and agreed with findings.

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_