MEDICAL HISTORY AND REVIEW OF SYSTEMS

NAME _____

PERSONAL PHYSICIAN _____

What are you being seen for today?

_____

_____

_____

Do You Have Any Allergies?

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Please Check If You Have Experienced Any of the Following:

GASTRO
- ☐ Stomach Ulcers
- ☐ Heartburn/Reflux
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Vomiting Blood
- ☐ Hepatitis

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ Murmur
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Heart Stent
- ☐ Peripheral Arterial Disease
- ☐ Chronic leg/ankle/foot swelling

GU
- ☐ Bladder infection
- ☐ Kidney Stone
- ☐ Frequent Urination
- ☐ Difficulty urinating
- ☐ Prostate Problems

MUSCULOSKELETAL
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Joint Pain
- ☐ Gout
- ☐ Fibromylgia

NEUROLOGIC
- ☐ Stroke
- ☐ Seizure
- ☐ Alzheimers/Memory Loss
- ☐ Fainting/Dizziness
- ☐ Parkinson's Disease

CONSTITUTIONAL
- ☐ Recent Change in Weight
- ☐ Lack of Energy
- ☐ Depression/Anxiety
- ☐ Change in Vision

PULMONARY
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Asthma

DERMATOLOGICAL
- ☐ Skin Disease
- ☐ Rash
- ☐ Non-healing wound/Ulcer

INFECTION
- ☐ Sexually Transmitted Disease

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disease

OTHER

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_____

_____

_____

CURRENT MEDICATIONS

_____

_____

_____

_____

_____ Date _____

Patient Signature

_____ Date _____

Reviewed by Physician Signature