

REVIEW OF MEDICAL SYSTEMS

Please answer the questions below to help us become informed about your general medical history. **Circle** if you have had:

CENTRAL NERVOUS SYSTEM

Persistent Headaches
Loss of consciousness
Head Trauma
Stroke
Epilepsy
Seizures, convulsions, fainting
Numbness
Tremors
Incoordination
Severe headaches
Other

NOSE

Nasal discharge
Nasal obstruction, nose bleed, breathing problem
Nasal trauma/Fracture
Sinus problems
Other

OROPHARYNX

Frequent sore throats
Throat pain
Pain with swallowing
Hoarseness
Tonsillitis
Difficulty swallowing

RESPIRATORY

Allergies
Asthma
Hay fever
Tuberculosis
Coughing blood
Wheezing
Difficulty breathing

GASTROINTESTINAL

Stomach problems
Ulcers
Reflux
Esophagitis
Abdominal pain
Jaundice
Hepatitis A, B, or C
Bowel problems
Blood in stool
Liver disease

EYES

Visual changes
Eye pain
Eye discharge
Eye injuries
Redness
Other

EARS

Difficulty hearing
Ear pain
Ear discharge
Dizziness
Vertigo
Tinnitus (Ringing, buzzing, etc)

NECK

Neck masses
Neck pain
Neck stiffness
Thyroid problems

CARDIOVASCULAR

Chest pain
Ankle swelling
Heart murmurs
Heart problems
High blood pressure
Heart attacks

GENITOURINARY

Voiding problems
Blood in urine
Kidney infections
Painful urination
Urinary tract infections

EXTREMITIES

Weakness
Joint Pain
Walking Problems
Muscle pains/cramps
Back problems

PSYCHIATRIC

Depression
Anxiety
Drug use/abuse
Alcohol use/abuse

FAMILY HISTORY

Hearing loss
Bleeding disorders
Cancer
Diabetes
Heart disease
Migraine Headaches

SKIN

Sores
Rashes
Hives
Itching
Color changing
Easy bruising
Easy bleeding

IMMUNE SYSTEM

Arthritis
Autoimmune problems
Venereal disease
Syphilis
Gonorrhea
HIV
Tuberculosis
Neurofibromatosis
Cancer

SIGNATURE: _____

DATE: _____

To allow us to help you more effectively, please provide the following information:

Height _____

Weight _____

What is the purpose of your visit?

Are you allergic to any medication? _____ **If so, please list:**

Are you currently taking any medication? _____ **If so, please list:**

Prior hospitalizations with dates excluding surgery:

Prior surgical procedures with dates:

Signature _____

Date: _____