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REVIEW OF MEDICAL SYSTEMS

Complete the form online.
Then FAX or bring it to your
appointment.

Please answer the questions below to help us become informed about your general medical history. **CHECK each 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

PSYCHIATRIC

- Depression
- Anxiety
- Drug use/abuse
- Alcohol use/abuse

NECK

- Neck stiffness
- Thyroid problems
- Neck pain
- Neck masses

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)

CARDIOVASCULAR

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

EXTREMITIES

- Weakness
- Joint Pain
- Walking Problems
- Muscle pains/cramps
- Back problems

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

GENITOURINARY

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

Signature _____ Date _____

To allow use 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? Yes No If so, please list:

Are you currently taking any medication? Yes No If so, please list:

Prior hospitalizations with dates (excluding surgery):

Prior surgical procedures with dates:

Signature _____ Date _____