



MEDICAL HISTORY AND REVIEW OF SYSTEMS

Today's Date: _____

Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Place of Birth: _____

Primary Care Physician: _____

Allergic to: None known Latex IV contrast dye Iodine Eggs Environmental

Medical allergies: _____

List surgeries/Year: _____

Do you wear contact lenses? NO YES If yes, type/brand: _____

Please *circle* any condition below with which you have been diagnosed- add comments as necessary

<u>Eyes:</u>	no problems	glaucoma injury	cataracts	macular degeneration
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<u>Cardiovascular:</u>	no problems	high blood pressure cardiac murmur pacemaker	heart attack atrial fibrillation	coronary artery disease congestive heart failure
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<u>Respiratory:</u>	no problems lung cancer	asthma home oxygen use	emphysema/COPD	tuberculosis
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<u>Endocrine:</u>	no problems	diabetes	thyroid disease	
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<u>Gastrointestinal:</u>	no problems	hepatitis A/B/C/D reflux disease	liver disease colon cancer	ulcers
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<u>Genitourinary:</u>	no problems	kidney disease prostate enlargement	dialysis prostate cancer	urinary tract infections kidney transplant
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<u>Neurologic:</u>	no problems	stroke multiple sclerosis	seizures Alzheimer's	Parkinson's disease psychiatric (list)
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<u>Heme/Immune:</u>	no problems	anemia bleeding disorder Other cancers (list)	leukemia lupus	lymphoma HIV/AIDS
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<u>Musculoskeletal:</u>	no problems	rheumatoid arthritis	osteoarthritis	osteoporosis
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<u>Dermatologic:</u>	no problems	psoriasis	eczema	rosacea
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<u>Other:</u>				
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Please circle any problem below which you have had recently

<u>Eyes:</u>	blurry vision, double vision, distorted vision, eye pain	Other: _____
<u>Ears/Nose/Throat:</u>	ear pain, stuffy nose, sore throat, dry mouth	Other: _____
<u>Cardiovascular:</u>	chest pain, palpitations	Other: _____
<u>Respiratory:</u>	shortness of breath, cough	Other: _____
<u>Endocrine:</u>	fatigue, hair loss	Other: _____
<u>Gastrointestinal:</u>	abdominal pain, diarrhea, constipation, blood in stool	Other: _____
<u>Genitourinary:</u>	painful urination, difficulty urinating, blood in urine	Other: _____
<u>Neurologic:</u>	headache, weakness, numbness, imbalance	Other: _____
<u>Heme/Immune:</u>	easy bruising, nosebleeds	Other: _____
<u>Musculoskeletal:</u>	joint pains, poor mobility	Other: _____
<u>Dermatologic:</u>	rash, sores	Other: _____

FAMILY HISTORY- Please tell us which of your blood relatives have/had the following problems

Diabetes: _____	Heart disease: _____	High blood pressure: _____	Stroke: _____
Glaucoma: _____	Macular Degeneration: _____	Cancer (type): _____	

SOCIAL HISTORY- Please tell us a bit about yourself

Occupation: _____
Hobbies/Interests: _____
Do you live alone? NO YES
Do you exercise? NO YES- type and frequency: _____
Do you drink alcohol? NO YES- type and frequency: _____
Do you smoke tobacco? NO YES- how much? _____ Age started: _____ Age quit: _____
Recreational drug use? NO YES- type and frequency: _____
Do you drive? NO YES
Please tell us who referred you to our practice: _____

Patient Signature:

Date:

Signature of person other than patient completing this form

Date: