

## Medical History & System Review Form

All new patients are required to complete and turn in a Patient Medical History & System Review Form prior to their first scheduled appointment. You should complete this form prior to the time of your first appointment and present it to the receptionist on the day you arrive to be seen.

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**PATIENT:**

\_\_\_\_\_

Last Name

First Name

Middle Initial/Name

\_\_\_\_\_

Social Security Number

Age

Height

Weight

Current Occupation

\_\_\_\_\_

MD Seen Today

Reason for Visit Today (Chief Complaint)

\_\_\_\_\_

Requesting MD (First & Last Name)

Requesting MD Location (Address, City, State)

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**HISTORY OF PRESENT ILLNESS:**

Where is the problem located? \_\_\_\_\_

Exactly what occurs that has caused you to seek treatment (numbness, pain, headache)? \_\_\_\_\_

\_\_\_\_\_

How long have you had this problem (days, weeks, months)? \_\_\_\_\_

\_\_\_\_\_

Does this problem occur at a certain time of the day or is it associated with a certain activity? Explain: \_\_\_\_\_

\_\_\_\_\_

Is this problem something that worsened over time or did it occur rapidly and recently? Explain: \_\_\_\_\_

\_\_\_\_\_

Are there activities, or things that you have found that make feel better? \_\_\_\_\_

\_\_\_\_\_

Are there activities, or things that you have found that make feel worse? \_\_\_\_\_

\_\_\_\_\_

On a scale of 1 to 10, with 10 being the worst, how much has this condition affected your daily activities? \_\_\_\_\_

Is this a work related injury?  Yes  No Date of Injury: \_\_\_\_\_ Are you currently working?  Yes  No

If off from work now, how long have you been off work? \_\_\_\_\_

How were you injured? \_\_\_\_\_

Is this a motor vehicle accident injury?  Yes  No Date of Injury? \_\_\_\_\_

**OTHER ILLNESSES OR CONDITIONS:**

Are you being treated for any other illnesses or conditions at the present time?  Yes  No If Yes, please list below:

Illness/Condition	Provider	Address (City/County)	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL HISTORY** (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| Polio <input type="checkbox"/>           | Glaucoma <input type="checkbox"/>           | Stroke <input type="checkbox"/>                    | Back Problems <input type="checkbox"/>          |
| Scarlet Fever <input type="checkbox"/>   | Venereal Disease <input type="checkbox"/>   | Kidney Disease <input type="checkbox"/>            | High Blood Pressure <input type="checkbox"/>    |
| Pneumonia <input type="checkbox"/>       | Anemia <input type="checkbox"/>             | Blood/Plasma Transfusions <input type="checkbox"/> | Heart Disease <input type="checkbox"/>          |
| Emphysema <input type="checkbox"/>       | Bladder Infections <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/>               | Heart Attack <input type="checkbox"/>           |
| Thyroid Disease <input type="checkbox"/> | Epilepsy <input type="checkbox"/>           | Hearing Loss <input type="checkbox"/>              | Heart Failure <input type="checkbox"/>          |
| Hepatitis <input type="checkbox"/>       | Arthritis <input type="checkbox"/>          | AIDS/HIV+ <input type="checkbox"/>                 | Bleeding/Blood Disease <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Bronchitis <input type="checkbox"/>         | Migraine Headaches <input type="checkbox"/>        | Tuberculosis <input type="checkbox"/>           |
| Diabetes <input type="checkbox"/>        | Asthma <input type="checkbox"/>             | Ulcers <input type="checkbox"/>                    | Hernia <input type="checkbox"/>                 |
- Cancer  If checked, what type of cancer: \_\_\_\_\_

Other Diseases? \_\_\_\_\_

**PATIENT SOCIAL HISTORY:**

- Marital Status:  Single  Married  Separated  Divorced  Widowed
- Alcohol Use:  Never  Rarely  Moderately  Daily - Quantity: \_\_\_\_\_
- Tobacco Use:  Never  Did smoke but stopped  Smoker - Quantity: \_\_\_\_\_
- Drug Use:  Never  Yes

Excessive Exposure at Home or Work (Check all that apply)  Fumes  Solvents  Dust  Airborne Particles

**FAMILY MEDICAL HISTORY:**

Relationship	Age	Diseases	If deceased, cause of death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



**CONSTITUTIONAL SYMPTOMS:**

**GENERAL**

- Good general health lately  Yes  No
- Recent weight change  Yes  No
- Fever  Yes  No
- Fatigue  Yes  No
- Headaches  Yes  No

**EYES**

- Eye disease or Injury  Yes  No
- Wear glasses/contact lenses  Yes  No
- Blurred or double vision  Yes  No

**EAR/NOSE/MOUTH/THROAT**

- Hearing loss or ringing  Yes  No
- Earaches or drainage  Yes  No
- Chronic sinus problems or rhinitis  Yes  No
- Nose bleeds  Yes  No
- Mouth sores  Yes  No
- Bleeding gums  Yes  No
- Bad breath or taste  Yes  No
- Sore throat or voice change  Yes  No
- Swollen glands in neck  Yes  No
- Vision loss  Yes  No
- Speech problems  Yes  No

**CARDIOVASCULAR:**

- Heart trouble  Yes  No
- Chest pain or angina pectoris  Yes  No
- Palpitations  Yes  No

- Shortness of breath walking or lying flat  Yes  No
- Swelling of feet, ankles or hands  Yes  No

**RESPIRATORY:**

- Chronic or frequent cough  Yes  No
- Spitting up of blood  Yes  No

- Shortness of breath  Yes  No
- Wheezing  Yes  No

**GASTROINTESTINAL:**

- Loss of appetite  Yes  No
- Painful bowel movements  Yes  No
- Constipation  Yes  No
- Rectal Bleeding or blood in stool  Yes  No

- Abdominal pain  Yes  No
- Change in bowel movement  Yes  No
- Nausea or vomiting  Yes  No
- Frequent diarrhea  Yes  No

**GENITOURINARY:**

- Frequent urination  Yes  No
- Burning or painful urination  Yes  No
- Blood in urine  Yes  No
- Change in force of strain when urinating  Yes  No
- Incontinence or dribbling  Yes  No
- Kidney stones  Yes  No
- Sexual difficulty  Yes  No

- Male – Testicle Pain  Yes  No
- Female – irregular periods  Yes  No
- Female – pain with periods  Yes  No
- Female – vaginal discharge  Yes  No
- Female – # of pregnancies \_\_\_\_\_
- Female – # of miscarriages \_\_\_\_\_

**MUSCULOSKELETAL:**

Joint pain	<input type="radio"/> Yes	<input type="radio"/> No	Back pain	<input type="radio"/> Yes	<input type="radio"/> No
Joint stiffness/swelling	<input type="radio"/> Yes	<input type="radio"/> No	Neck pain	<input type="radio"/> Yes	<input type="radio"/> No
Weakness – muscles	<input type="radio"/> Yes	<input type="radio"/> No	Cold extremities	<input type="radio"/> Yes	<input type="radio"/> No
Muscle pain or cramps	<input type="radio"/> Yes	<input type="radio"/> No	Difficulty in walking	<input type="radio"/> Yes	<input type="radio"/> No

**INTEGUMENTARY:**

Rash or itching	<input type="radio"/> Yes	<input type="radio"/> No	Breast pain	<input type="radio"/> Yes	<input type="radio"/> No
Change in skin color	<input type="radio"/> Yes	<input type="radio"/> No	Breast lump	<input type="radio"/> Yes	<input type="radio"/> No
Varicose veins	<input type="radio"/> Yes	<input type="radio"/> No	Breast discharge	<input type="radio"/> Yes	<input type="radio"/> No

**NEUROLOGICAL:**

Frequent headaches	<input type="radio"/> Yes	<input type="radio"/> No	Tremors	<input type="radio"/> Yes	<input type="radio"/> No
Light headed or dizzy	<input type="radio"/> Yes	<input type="radio"/> No	Paralysis	<input type="radio"/> Yes	<input type="radio"/> No
Convulsions or seizures	<input type="radio"/> Yes	<input type="radio"/> No	Head Injury	<input type="radio"/> Yes	<input type="radio"/> No
Numbness or tingling	<input type="radio"/> Yes	<input type="radio"/> No			

**PSYCHIATRIC:**

Memory loss or confusion	<input type="radio"/> Yes	<input type="radio"/> No	Depression	<input type="radio"/> Yes	<input type="radio"/> No
Nervousness	<input type="radio"/> Yes	<input type="radio"/> No	Insomnia	<input type="radio"/> Yes	<input type="radio"/> No

**ENDOCRINE:**

Glandular or hormone problem	<input type="radio"/> Yes	<input type="radio"/> No	Skin becoming drier	<input type="radio"/> Yes	<input type="radio"/> No
Excessive thirst or urination	<input type="radio"/> Yes	<input type="radio"/> No	Change in hat or glove size	<input type="radio"/> Yes	<input type="radio"/> No
Heat or cold intolerance	<input type="radio"/> Yes	<input type="radio"/> No			

**HEMATOLOGIC/LYMPHATIC:**

History of skin reaction or other adverse effect	<input type="radio"/> Yes	<input type="radio"/> No	Phlebitis	<input type="radio"/> Yes	<input type="radio"/> No
Bleeding or bruising tendency	<input type="radio"/> Yes	<input type="radio"/> No	Past blood transfusion	<input type="radio"/> Yes	<input type="radio"/> No
Anemia	<input type="radio"/> Yes	<input type="radio"/> No	Enlarged glands	<input type="radio"/> Yes	<input type="radio"/> No

**ALLERGIC/IMMUNOLOGIC:**

Known food allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Known environmental allergies

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_