Medical History Form & Review of Systems

Name ____ Date _________________________

Patient Social History:

Use of Alcohol: Never ☐ Rarely ☐ Moderate ☐ Daily ☐

Use of Tobacco: Never ☐ Previously/Quit (date) _______________ Current Packs/day _____

Use of Drugs: Never ☐ Type/Frequency ____________________________

Occupation __________________________________

Past Medical History:

☐ Thyroid Disease ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke

☐ HIV ☐ Hepatitis ☐ Diabetes ☐ Cancer

☐ Do you have a defibulator?

Other: ____

Description of Previous Surgery/Date ____

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Medications: (include non-prescription) ____

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Are you allergic to any medications? No ☐ Yes ☐ If yes, list medication(s)_________________________________

Review of Systems: Do you have any of the following TODAY?

Gastrointestinal
- ☐ Heartburn/Reflux
- ☐ Nausea/vomitary/diarrhea

Skin
- ☐ Rash

Neurological/Head
- ☐ Headaches
- ☐ Weakness
- ☐ Migraines

Ears/Nose/Throat/Mouth/Neck
- ☐ Hay fever/allergies/congestion
- ☐ Sinusitis
- ☐ Neck Problems

Genitourinary
- ☐ Painful/Bloody Urine
- ☐ Leaking Urination

Psychiatric
- ☐ Anxiety/Stress
- ☐ Sleep Problems
- ☐ Psychiatric Illness

Cardiovascular
- ☐ Chest Pains/Discomfort
- ☐ Palpitations
- ☐ Shortness of breath with exertion

Musculoskeletal
- ☐ Muscle/joint pain/arthritis
- ☐ Recent back pain

Respiratory
- ☐ Cough/wheeze
- ☐ Shortness of Breath

Blood/Lymphatic
- ☐ Blood Disease
- ☐ Unexplained lumps

☐

Patient Signature __________________________ Technician Signature ________________________________