

Review of Systems:

MEDICAL HISTORY Mark (C) for current problems. Check ( ) and indicate age when you had any of the following symptoms or diseases.

- |                                 |                                       |                                       |
|---------------------------------|---------------------------------------|---------------------------------------|
| ( ) Decreased hearing           | ( ) Heartburn ( ) Peptic Ulcer        | ( ) Numbness/Tingling Sensations      |
| ( ) Ringing in Ear              | ( ) Persistent Nausea/Vomiting        | ( ) Headaches – frequent              |
| ( ) Ear Infections – frequent   | ( ) Abdominal Pain – chronic          | ( ) Arthritis/Rheumatism              |
| ( ) Dizzy Spells                | ( ) Gall Bladder Trouble              | ( ) Back Pain – recurrent             |
| ( ) Fainting Spells             | ( ) Jaundice/Hepatitis                | ( ) Bone Fracture/Joint Injury        |
| ( ) Failing Vision ( ) Eye pain | ( ) Change in Bowel Habits            | ( ) Gout ( ) Osteoporosis             |
| ( ) Double or Blurred Vision    | ( ) Diarrhea ( ) Constipation         | ( ) Foot Pain ( ) Cold Numb Feet      |
| ( ) Eye infections – frequent   | ( ) Diverticulosis ( ) Chrohn/Colitis | ( ) Rashes ( ) Hives                  |
| ( ) Nose Bleeds – recurrent     | ( ) Bloody or Tarry Stools            | ( ) Psoriasis ( ) Eczema              |
| ( ) Sinus Trouble               | ( ) Hemorrhoids ( ) Hernia            | ( ) Sleeping – difficulty             |
| ( ) Sore Throat – frequent      | ( ) Urine infections – frequent       | ( ) Depression ( ) Nervousness        |
| ( ) Hay fever/Allergies         | ( ) Blood in urine ( ) Kidney Stones  | ( ) Memory Loss                       |
| ( ) Hoarseness – prolonged      | ( ) Urination – overnight than twice  | ( ) Moodiness – excessive             |
| ( ) Pneumonia/Pleurisy          | painful loss of control               | ( ) Mental Illness ( ) Phobias        |
| ( ) Bronchitis/Chronic cough    | decrease in force/flow                | ( ) Rheumatic Fever ( ) Scarlet Fever |
| ( ) Asthma/Wheezing             | ( ) Venereal Disease                  | ( ) Chicken Pox ( ) Polio ( ) Mumps   |
| ( ) Shortness of Breath:        | ( ) Urethral Discharge                | ( ) Measles ( ) German Measles        |
| on exertion lying flat          | ( ) Chronic Fatigue                   | ( ) Tuberculosis ( ) Herpes           |
| ( ) Chest Pain                  | ( ) Weight Loss – recent              | ( ) Alcohol oz. Per week              |
| ( ) High Blood Pressure         | ( ) Anemia ( ) Bruise Easily          | ( ) Smoking __cig/day __# yrs.        |
| ( ) Heart Murmur                | ( ) Cancer ( ) Diabetes               | yr. quit _____                        |
| ( ) Swollen Ankles              | ( ) Thyroid Disease                   | ( ) Coffee/Tea __cups per day         |
| ( ) Irregular Pulse             | ( ) Seizures ( ) Stroke               | ( ) Regular Exercise                  |
| ( ) Palpitations                | ( ) Tremor/Hands Shaking              |                                       |
| ( ) Leg pain – when walking     | ( ) Muscle Weakness                   | FEMALES – Please complete             |
| ( ) Varicose Veins/Phlebitis    |                                       | Menstrual Flow:                       |
| ( ) Loss of Appetite – recent   |                                       | ( ) Reg. ( ) Irreg. ( ) Pain/Cramps   |

difficulty Swallowing

Birth Control Method \_\_\_\_\_

B.C. Pill (name) \_\_\_\_\_