MEDICAL HISTORY - SYSTEM REVIEW

Name:____ Date:_______________________

Have you ever been treated for:

Cardiovascular:	**Yes**	**No**
1. Rheumatic Fever	______	______
2. Heart Trouble	______	______
3. High Blood Pressure	______	______
4. Chest Pains, Angina	______	______
5. Shortness of Breath	______	______
6. Smothering at Night	______	______
7. Swelling of Feet, Ankles	______	______
8. Varicose Veins	______	______
Muscular Skeletal:		
1. Arthritis	______	______
2. Swelling Joints	______	______
3. Back Trouble	______	______
Psychiatric:		
1. Mental Disease	______	______
2. Tension	______	______
3. Nervousness	______	______
4. Worries	______	______
5. Sleep Issues	______	______
Respiratory:		
1. Asthma	______	______
2. Tuberculosis	______	______
3. Pneumonia, Pleurisy	______	______
4. Lung Trouble	______	______
5. Cough	______	______
6. Bronchitis	______	______
7. Spitting Up Blood	______	______
ENT:		
1. Disorder of Ears, Nose, Throat	______	______
2. Headache	______	______
3. Sinus Trouble	______	______
Endocrinology:		
1. Thyroid Trouble	______	______
2. Diabetes	______	______
3. Other________________		
Eyes:		
1. Transient Blindness	______	______
2. Cataracts	______	______
3. Glasses/Contacts	______	______
4. Glaucoma	______	______

Females Only:

Pregnancies ____________________

Miscarriages ____________________

Last Menstrual Period ____________________

Are you regular ____________________

Excess Bleeding ____________________

Gastroenterology:	**Yes**	**No**
1. Loss of Appetite	______	______
2. Ulcer	______	______
3. Vomiting Blood	______	______
4. Black Tarry Stools	______	______
5. Chronic Indigestion	______	______
6. Belching Gas	______	______
7. Gallbladder Trouble	______	______
8. Liver Trouble	______	______
9. Hemorrhoids	______	______
10. Rupture	______	______
11. Diarrhea	______	______
12. Constipation	______	______
13. Rectal Bleeding	______	______
14. Stomach Pain	______	______
15. Weight Loss	______	______
Urology:		
1. Pain on Urination	______	______
2. Burning on Urination	______	______
3. Strain to Urinate	______	______
4. Urine at Night	______	______
5. Prostate Trouble	______	______
6. Venereal Disease	______	______
Skin:		
1. Skin Disease	______	______
2. Rash	______	______
Neurology:		
1. Convulsions	______	______
2. Epilepsy	______	______
3. Paralysis	______	______
4. Stroke	______	______
Breasts:		
1. Lumps	______	______
2. Pain	______	______
3. Discharge	______	______
Cancer	______	______

Type: ____

Allergies **Reaction**

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Current Medications **Dosage**

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