MEDICAL HISTORY FORM PAGE 2

REVIEW OF SYSTEMS

Systemic

Fever	Y	N
Weight Change	Y	N
Fatigue	Y	N
Weakness	Y	N

Neck

Pain	Y	N
Lumps	Y	N
Swollen Glands	Y	N

Eye

Blurry Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Psychological

Depressed	Y	N
Anxiety	Y	N
Sleep Issues	Y	N

Nervous System

Headache	Y	N
Dizziness	Y	N
Fainting	Y	N

Ears/Nose/Throat

Hearing Loss	Y	N
Ear Ringing	Y	N
Sore Throat	Y	N
Hoarseness	Y	N

Heart

Chest Pain	Y	N
Palpitations	Y	N
Shortness of Breath	Y	N

Lung

Difficulty Breathing	Y	N
Wheezing	Y	N
Coughing up Blood	Y	N

Glands

Hair Loss	Y	N
Weakness	Y	N

Bones/Joint

Joint Pain	Y	N
Joint Swelling	Y	N
Back Pain	Y	N
Joint Stiffness	Y	N

Stomach/Intestines

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Stool Change	Y	N
Diarrhea	Y	N
Constipation	Y	N
Hemorrhoids	Y	N
Blood in Stool	Y	N

Bladder

Burning w Frequency	Y	N
Night-time Urination	Y	N

Circulation

Easy Bleeding	Y	N
Anemia	Y	N

Skin

Hives	Y	N
Mole Change	Y	N

Family History: ***Please list specific family member (father, mother, brother, sister, maternal or paternal grandparent)***

Breast Cancer: _____ Diabetes: _____

Cervical Cancer: _____ Thyroid Disorders: _____

Colon Cancer: _____ Obesity: _____

Lung Cancer: _____ Crohn's Disease: _____

Ovarian Cancer: _____ Colitis: _____

Prostate Cancer: _____ COPD: _____

Uterine Cancer: _____ Other: _____

Heart Disease: _____ _____

Stroke: _____ Hypertension: _____

NAME: _____ ***DOB***: _____