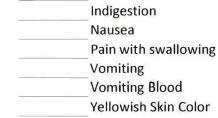
Adult Medical History Form	please print	Appoin	tment Date:
Patient name:		DOB:	/ /
* Complete entire form unless you have prev and any others	· ·	m, in which case you may uch as a change in marital	
* Reason for visit or current problem: (Include date of onset or injury)		Medication & doses:	
Past medical problems:			
Hospitalizations & operations: Yea	ar	Allergies: (Include rea	action)
1 0	quit	Asthma: Depression/suicide: Diabetes: *Heart attack < 65 yr. *Heart attack < 55 yr. High blood pressure: High cholesterol: Osteroporosis: Stroke: Breast cancer: Ovarian cancer: Prostate cancer: Social History: <u>Marital status:</u> (circle)	female: male: single married widowed live w/ partner
*HIV high risk behavior: □ No □ Ye *Caffine: □ No □ Yes drinks per *Alcohol: □ No □ Yes drinks per *Exercise: Times per week	r day: r day: r day:	Children: (first name a Occupation: (present o	and year born) or previous) 🗆 Retired
Type(s):	□ usually □ never al □ rare	College/tech Religion affects health	(circle one) high school grad/professional n care: □ No □ Ycs
Last tetanus booster:			



Review of Systems Please check any symptoms you are experiencing.

General	Eyes
Chills	Blurred Vision
Daytime Sleepiness	Discharge From Eye
Fatigue	Double Vision
Fever	Eye Irritation
Loss of Appetite	Eye Pain
Night Sweats	Light Sensitivity
Severe Snoring	Loss of Vision
Trouble sleeping	
Unexpected Weight Loss	Cardio-vascular
	Chest Pain or Discomfort
Ears / Nose / Throat	Calf Pain with Walking
Decreased Hearing	Difficulty Breathing at Night
Difficulty Swallowing	Difficulty Breathing Laying Down
Ear Discharge	Fainting or Near Fainting
Earache	Leg Cramps
Face or Jaw Pain	Lightheadedness
Hoarseness	Palpitations or Racing Heart
Nasal Congestion	Recent Weight Gain
Nosebleeds	Shortness of Breath with Exertion
Post Nasal Discharge	Swelling in Feet or Legs
Ringing in the Ears	
Sore Throat	
	Respiratory
Breast	Chest Pain with Deep Breaths
Abnormal Mammogram	Cough
Breast Enlargement	Coughing Up Blood
Breast Pain	Excessive Mucus or Phlegm
Breast Lump	Excessive Snoring
Nipple Discharge	Shortness of Breath
/	Wheezing
Gastro-Intestinal	
Abdominal Bloating	Heartburn
Abdominal Pain	Hemorrhoids
Bloody Stools	Indigestion
Change in Bowel Habits	Nausea

- Constipation
- Dark Tarry Stools
- _____ Diarrhea Difficulty swallowing





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	Genitourinary - WOMEN	Genitourinary - MEN	
	Blood in Urine	Blood in Urine	
	Decreased Sex Drive	Decreased Sex Drive	
	Vaginal Discharge	Discharge From Penis	
	Pain with urination	Pain with urination	
	Genital Sores	Erectile Dysfunction	
	Heavy or Prolonged Periods	Genital Sores	
	Hot Flashes	Night time urination	
	Irregular or Missed Periods	Trouble Starting Urine	
	Night time urination	Frequent Urination	
	Pain with Intercourse	Urinary Urgency	
	Painful Periods	Leaking Urine	
	Pelvic Pain	Possible HIV Exposure	
	Spotting		
	Trouble starting Urine	Musculoskeletal	
	Frequent Urination	Neck Pain	
	Urinary Urgency	Upper Back Pain	
	Leaking Urine	Low Back Pain	
	Possible HIV Exposure	General Weakness	
		Joint Pain	
	Dermatology	Joint Swelling	
	Change in Hair or Nails	Muscle Aches	
	Dry Skin	Muscle Cramps	
	Excessive Perspiration	Muscle Weakness	
	Itching	Stiffness	
	Non-Healing sores		
_	Rash	Neurological	
	Suspicious Mole or Growth	Arm & Leg Weakness	
	Unusual Hair Distribution	Confusion	
		Dizziness or Sensation of Spinning	
	Psych	Facial Weakness	
	Anxious Mood	Falling Down	
	Depressed Mood	Headaches	
	Excessive Worrying	Loss of Consciousness	
	Fears or Phobias	Numbness or Tingling	
	Frightening Visions or Sounds	Poor Balance or Coordination	
	Sleep Problems	Poor Memory	
	Thoughts of Suicide	Seizures or Uncontrolled Movements	
	Thoughts of Violence to Others	Slurred Speech	
		Tremors	
	Endo	Trouble with Concentration	

Cold Intolerance
Excessive Hunger
Excessive Thirst
Excessive Urination
Heat Intolerance
Weight Change

Infectious Disease HIV Exposure

Heme

Enlarged Glands Excessive or Easy Bruising

Visual Disturbances

Allergy Hives or Rash Persistent Infections Seasonal Allergies

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