Review of Systems
Past Medical History

Do you now have?	Have you ever had in the past?	***"Do you now have?"*** refers to your present symptoms. ***"Have you ever had in the past?"*** refers to your past history.	Do you now have?	Have you ever had in the past?	**Check off only which apply**	Do you now have?	Have you ever had in the past?	
		General:			**Ears:**			**Cardiac:**
☐	☐	Excessive Fatigue	☐	☐	Discharge	☐	☐	Arrhythmia
☐	☐	Unusual Fever	☐	☐	Dizziness	☐	☐	Chest pain
☐	☐	Weight gain/loss	☐	☐	Earaches	☐	☐	Congestive heart failure
☐	☐	Chemotherapy	☐	☐	Hearing impaired	☐	☐	Deep venous thrombosis
☐	☐	Radiation	☐	☐	Infection	☐	☐	Difficulty breathing
☐	☐	Sexually transmitted disease	☐	☐	Tinnitus-ringing in ears	☐	☐	Dyspnea
☐	☐	Excessive Weakness	☐	☐	Vertigo	☐	☐	Edema/Leg swelling
☐	☐	Other	☐	☐	Other	☐	☐	Fainting
☐	☐					☐	☐	Fibrillation
☐	☐	**Skin:**			**Nose & Sinuses:**	☐	☐	Heart attack
☐	☐	Change in hair or nails	☐	☐	Frequent colds	☐	☐	Heart Failure
☐	☐	Color change	☐	☐	Hoarseness	☐	☐	Heart murmurs
☐	☐	Dryness	☐	☐	Sore tongue	☐	☐	Heart trouble
☐	☐	Itching	☐	☐	Unusual Tooth cavities	☐	☐	High blood pressure
☐	☐	Lumps	☐	☐	Other	☐	☐	Hypertension
☐	☐	Rashes				☐	☐	Hypotension
☐	☐	Other			**Neck:**	☐	☐	Irregular heart beat
			☐	☐	Goiter	☐	☐	Mitral valve prolapse
		Head:	☐	☐	Lumps in neck	☐	☐	Palpitations
☐	☐	Excessive Headache	☐	☐	Pain in the neck	☐	☐	Rheumatic fever
☐	☐	Head injury	☐	☐	Swollen glands	☐	☐	Other
☐	☐	Other	☐	☐	Other			
								Peripheral Vascular:
		Eyes:			**Respiratory:**	☐	☐	Excessive Leg cramps
☐	☐	Blurred vision	☐	☐	Asthma	☐	☐	Intermittent claudication
☐	☐	Cataracts	☐	☐	Bronchitis	☐	☐	Thrombophlebitis
☐	☐	Double vision	☐	☐	Cough	☐	☐	Varicose veins
☐	☐	Excessive tearing	☐	☐	Emphysema			
☐	☐	Glasses or contact lenses	☐	☐	Hemoptysis			**Psychiatric:**
☐	☐	Glaucoma	☐	☐	Pleurisy	☐	☐	Anxiety disorder
☐	☐	Pain	☐	☐	Pneumonia	☐	☐	Depression
☐	☐	Redness	☐	☐	Shortness of breath	☐	☐	Manic depression/bipolar
☐	☐	Impaired vision	☐	☐	Tuberculin test	☐	☐	Mood
☐	☐	Other	☐	☐	Tuberculosis	☐	☐	Nervousness
			☐	☐	Wheezing	☐	☐	Schizophrenia
☐	☐	Tobacco use	☐	☐	Other	☐	☐	Tension
☐	☐	Alcohol use				☐	☐	Other

Turn over

Do you now have?	Have you ever had in the past?		Do you now have?	Have you ever had in the past?	**Check off only which apply**	Do you now have?	Have you ever had in the past?	
		Gastrointestinal:			**Urinary:**			**Neurologic:**
☐	☐	Abdominal pain	☐	☐	Dysuria	☐	☐	Alzheimer's disease
☐	☐	Poor appetite	☐	☐	Hematuria	☐	☐	Blackouts
☐	☐	Black tarry stools	☐	☐	Hesitancy	☐	☐	Cerebrovascular accident
☐	☐	Cirrhosis	☐	☐	Incontinence	☐	☐	Convulsions
☐	☐	Change in bowel habits	☐	☐	Increased frequency	☐	☐	Dementia
☐	☐	Colitis	☐	☐	Nocturia	☐	☐	Epilepsy
☐	☐	Colon cancer	☐	☐	Polyuria	☐	☐	Fainting
☐	☐	Colon polyps	☐	☐	Urinary Stones: Bladder/Kidney	☐	☐	Hemiplegia/Hemiparesis
☐	☐	Unusual Constipation	☐	☐	Urgency	☐	☐	Low back pain
☐	☐	Diverticulosis / Diverticulitis	☐	☐	Urinary infections	☐	☐	Local weakness
☐	☐	Excessive Diarrhea	☐	☐	Chronic Renal Failure / Dialysis	☐	☐	Memory
☐	☐	Excessive belching				☐	☐	Migraine Headache
☐	☐	Food intolerance			**Musculoskeletal:**	☐	☐	Mini stroke or TIA
☐	☐	Gallbladder trouble	☐	☐	Arthritis	☐	☐	Multiple sclerosis
☐	☐	Gastritis	☐	☐	Backache	☐	☐	Numbness
☐	☐	Heartburn	☐	☐	Leg cramps	☐	☐	Pain in arm or legs
☐	☐	Hemorrhoids	☐	☐	Gout	☐	☐	Paralysis
☐	☐	Hepatitis A B C	☐	☐	Joint pains	☐	☐	Parkinson's disease
☐	☐	Hiatal hernia	☐	☐	Muscle pains	☐	☐	Seizures
☐	☐	Indigestion	☐	☐	Muscle weakness	☐	☐	Sciatica
☐	☐	Jaundice	☐	☐	Osteoporosis	☐	☐	Stroke
☐	☐	Liver problems	☐	☐	Stiffness	☐	☐	Tingling
☐	☐	Unusual Nausea	☐	☐	Trouble opening mouth (TMJ)	☐	☐	Tremors
☐	☐	Pancreatitis	☐	☐	Other	☐	☐	Other
☐	☐	Unusual Passing of gas						
☐	☐	Rectal bleeding			**Endocrine:**			**Hematological:**
☐	☐	Trouble swallowing	☐	☐	Diabetes-insulin dependant	☐	☐	Anemia
☐	☐	Ulcer problems	☐	☐	Diabetes-non-insulin dependant	☐	☐	Easy bruising
☐	☐	Unusual Vomiting	☐	☐	Excessive sweating	☐	☐	HIV
☐	☐	Vomiting blood	☐	☐	Excessive thirst	☐	☐	AIDS
☐	☐	Other	☐	☐	Heat or cold intolerance	☐	☐	Past transfusions
			☐	☐	Hyperthyroidism	☐	☐	Possible reactions
			☐	☐	Hypothyroidism	☐	☐	Sickle cell anemia or trait
			☐	☐	Porphyria	☐	☐	Unusual bleeding or bruising
			☐	☐	Other	☐	☐	Other

☐ I refuse to fill this out **Signature** ____ **Date** ________

Remember! If you do not give me a complete and accurate history,
I cannot give you a complete and accurate diagnosis and treatment!