CONFIDENTIAL PATIENT MEDICAL HISTORY FORM and REVIEW OF SYSTEMS

Name: ______________________ **Primary Care Doctor:** ______________________

Age: __________ **Date** __________ **Send Report of Exam To:** ______________________

Review of Systems:

Do you have now or have you had:	Circle One	Explanation
1. Recent Fever	Yes / No	________
2. Extreme Unplanned Weight Gain/Loss	Yes / No	________
3. Ears, Nose, Throat Problems: Sinus Disease, Vertigo, Dry Mouth, Difficulty Swallowing	Yes / No	________
4. Heart Disease: Angina, Heart Attack, Blood Pressure, Other	Yes / No	________
5. Lung Disease: Asthma, Emphysema, Shortness of Breath, Chronic Obstructive Pulmonary Disease, Congestion, Wheezing, Other	Yes / No	________
6. Stomach Upset, Ulcer, Diarrhea, Constipation	Yes / No	________
7. Urinary Problems, Prostate Discharge	Yes / No	________
8. Muscle/Joint Pain or Weakness, Rheumatoid Arthritis, Other	Yes / No	________
9. Skin Conditions, Nail or Hair Problems: Eczema, Psoriasis, Rosacea, Changing Skin Spots, Other	Yes / No	________
10. Stroke, Seizures, Memory Loss, Weakness, Depression, Anxiety, Hallucinations, Other	Yes / No	________
11. Bleeding Problems, Bruising, Anemia, Sickle Cell Disease, Other	Yes / No	________
12. Endocrine: Diabetes - Indicate how long and what type	Yes / No	________
Thyroid, Cholesterol, Other	Yes / No	________
13. HIV / AIDS	Yes / No	________
14. Cancer - Indicate how long, what type	Yes / No	________

15. Other: ______________________

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Current Medications:

Prescription: ______________________

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Over the Counter: ______________________

Allergies to Medications: ______________________

Form Completed by: Patient ______ Family ______ Staff ______ Other: ______________

Patient / Guardian Signature: ______________________

Reviewed by: ______________________ **Date:** __________