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**

Current Medications	**Dosage**