SYSTEMS REVIEW

Patient Name: _____ #: _____ Date: ____/_____/_____

Thank you for completing this detailed health history. Please **circle** each individual answer and provide additional information when indicated. Include both ***past*** and ***present*** conditions. If you are not sure what a question means, leave it blank. Your intern and faculty doctor will review it with you later.

Please return the completed form to the receptionist or your intern when you are finished. Thank you.

Family History

001: Y N Diabetes
002: Y N Thyroid disease, Type: _____
003: Y N Tuberculosis
004: Y N Kidney disease, Type: _____
005: Y N High blood pressure, high cholesterol, or triglycerides
006: Y N Heart Attack, other heart disease, Type: _____
007: Y N Musculoskeletal disease Type:_____
008: Y N Cancer Type: _____
009: Y N Stroke, aneurysm, blood clot, deep vein thrombosis
010: Y N Osteoporosis
011: Y N Other family history

Patient's Current General History

012: Y N Recent weight change, ↑ or ↓
Why?_____
How much? _____ lbs
013: Y N On-going fever / chills
014: Y N Periodic unexplained sweats
015: Y N Allergies (please mark symptoms)
016: Y N Anemia
017: Y N Bleeding / bruising
018: Y N Malaise / fatigue / weakness
019: Y N HIV positive – with / without symptoms?
Diagnosed by Date

020: Y N Cancer
Type: _____
021: Y N Insomnia, sleeping difficulty
022: Y N Other general history

Endocrine History

023: Y N Heat / cold intolerance
024: Y N Thyroid conditions:
❑ Hypo ❑ Hyper
025: Y N Diabetes
026: Y N Insulin Dependent
027: Y N Non-Insulin Dependent
028: Y N Neck surgery / irradiation
029: Y N Other glandular conditions

Eye / Ear / Nose / Throat

030: Y N Corrective Lenses
031: Y N Eyes redden, swell, tear, or itch
Y N Is it due to allergies?
032: Y N Other eye pain
033: Y N Cataracts
034: Y N Glaucoma
035: Y N Detached Retina
036: Y N Macular Degeneration
037: Y N Other Visual Conditions
038: Y N Difficulty hearing / deafness
039: Y N Ringing in ears / dizziness
040: Y N Ear growths / discharge
041: Y N Ear pain
042: Y N Nosebleeds
043: Y N Change in ability to smell
044: Y N Sneezing
045: Y N Nose growths / discharge / post nasal drip
046: Y N Nose pain
047: Y N Sinus pain / congestion / infection
048: Y N Other nose conditions

049: Y N Hoarseness / throat pain or soreness
050: Y N Change in voice
051: Y N Difficulty chewing or swallowing
052: Y N Enlarged / painful glands, where?

053: Y N Change in ability to taste
054: Y N Growths / lesions in mouth or throat
055: Y N Dental conditions
056: Y N Other throat or mouth conditions

Gastrointestinal System

057: Y N Change in appetite ↑ or ↓
058: Y N Food intolerance
059: Y N Nausea / vomiting
060: Y N Vomiting blood
061: Y N Peptic ulcer
Diagnosed by Date

062: Y N Indigestion / heartburn / excessive belching
063: Y N Abdominal pain (stomach)
064: Y N Abdominal swelling / bloating
065: Y N Change in bowel habits or stool (color, consistency etc.)
066: Y N Diarrhea / Constipation / IBS

Patient Name: _____ File #: _____

067: Y N Hernia ❑ Hiatal ❑Femoral ❑Inguinal
Diagnosed by Date

068: Y N Did you have surgery?
069: Y N Hemorrhoids
070: Y N Gallbladder disease
Diagnosed by Date

071: Y N Did you have surgery?
072: Y N Liver disease
Type? _____
Diagnosed by Date

073: Y N Pancreas disorder / inflammation
074: Y N Alcohol intake Type: _____
Amount: _____
075: Y N Other gastrointestinal conditions

Pulmonary System

076: Y N Difficulty breathing
077: Y N Cough / hacking
078: Y N Cough up blood / phlegm
079: Y N Wheezing / asthma
080: Y N Tuberculosis / TB exposure / TB test
or X-Ray Date: _____
081: Y N Respiratory infections or pneumonia
Diagnosed by Date

082: Y N Cigarette smoking: past / present
Daily # _____ # years _____
083: Y N Other tobacco use: past / present
❑ Cigar ❑Pipe ❑ Chewing tobacco
Daily # _____ # years _____
084: Y N Exposure to dangerous fumes, toxic chemicals or excessive pollution
Type: _____
Amount: _____
Duration: _____
085: Y N Other pulmonary conditions

Cardiovascular System

086: Y N Shortness of breath
From exercise? Y N
Time of day _____ How often _____
087: Y N Chest discomfort / pain
Type _____
How often _____
088: Y N Palpitations _____
089: Y N Edema
Type _____
090: Y N Fainting / loss of consciousness
091: Y N Blood clots, deep vein thrombosis, aneurysm
092: Y N Sudden calf pain while walking
How often _____
093: Y N High blood pressure
094: Y N High cholesterol
095: Y N High triglycerides
096: Y N Taking medication to control?
Diagnosed by Date

097: Y N Past heart or vascular disease
Type: _____
Diagnosed by Date

098: Y N Rheumatic fever
Diagnosed by Date

099: Y N Other heart / circulatory conditions

Urinary System

100: Y N Frequent urination
times per day ____ # per night ____
Daily fluid intake _____
101: Y N Increased thirst
102: Y N Urinary urgency / pain
103: Y N Change in urine (color, blood, etc.)
104: Y N Hesitancy
105: Y N Difficulty in holding urine
106: Y N Urethral discharge
107: Y N Urinary tract infections
Diagnosed by Date

108: Y N Kidney disease / Stones
Diagnosed by Date

109: Y N Kidney / flank (side) pain
110: Y N Pelvic pain
111: Y N Pelvic mass
112: Y N Other genitourinary conditions

Breasts (Male and Female)

113: Y N Breast lumps / mass / growths / pain / tenderness
114: Y N Dimples in breast
115: Y N Change in color / size / shape
116: Y N Nipple discharge / bleeding
117: Y N Other breast conditions

Reproductive System

118: Y N Genital lesions
119: Y N Genital mass / growths / pain
120: Y N Other genital conditions
121: Y N Other reproductive issues

Patient Name: _____ File #: _____

Skin / Hair / Nails

122: Y N Change in skin texture
123: Y N Change in skin temperature
124: Y N Excessive skin dryness or perspiration
125: Y N Unusual skin coloration
126: Y N Rashes / itching / lesions
127: Y N Skin growths
128: Y N Mole changes
129: Y N Skin Cancer Location:

130: Y N Skin Pain Location:

131: Y N Change in hair texture / condition
132: Y N Change in hair growth or loss
133: Y N Change in shape of fingernails or toenails
134: Y N Change in color or condition of nails
135: Y N Other skin or hair conditions

Neurological System

136: Y N Headaches
How often? _____
137: Y N Seizures / Epilepsy
138: Y N Tics / involuntary twitches / spasms
139: Y N Vertigo / Dizziness / feel faint
140: Y N Loss of sensation, sensory disturbance (numbness or tingling)
141: Y N Unusual weakness
142: Y N Head Trauma
Type Date

143: Y N Stroke / multiple sclerosis
Diagnosed by Date

144: Y N Vertebral disk rupture / herniation
Level (s) _____
145: Y N Other neurological conditions

Musculoskeletal System

146: Y N Joint stiffness / change in range of motion
147: Y N Joint pain / ache
148: Y N Joint swelling
149: Y N Muscle cramps / soreness / pain
150: Y N Muscle weakness
151: Y N Muscle wasting
152: Y N Neck pain
153: Y N Upper back pain / mid back pain
154: Y N Low back pain
155: Y N Buttock pain
156: Y N Shoulder / arm / hand condition
Which side? Left Right
Problem _____

157: Y N Leg / knee / ankle / foot condition
Which side? Left Right
Problem _____
158: Y N Fractures / dislocation / sprains
Location Date

159: Y N Other injuries, or traumas– include auto accidents(even minor ones), sports injuries and work related accidents
Accident Date

160: Y N Osteoporosis / Fibromyalgia
161: Y N Other musculoskeletal / orthopedic conditions

Hospitalizations / Medications

162: Y N Hospitalizations, Emergency room visits, surgeries
What? Why? Date(s)

163: Y N Current medications or drugs (include prescription, over-the-counter or recreational)
Medication Reason

Mental / Psychological History

164: Y N Anxiety / Bipolar
165: Y N Depression
166: Y N Hospitalization for psychological care
167: Y N ADD / ADHD,/ retardation / impairment
168: Y N Other psychological conditions

Patient Name: _____ File #: _____

Diet / Exercise

169: Y N Eat a healthy diet
170: Y N Have an unusual appetite
❑ large ❑ small
171: Y N Consume caffeine
_____/day or wk
172: Y N Consume alcohol
_____/day or wk
173: Y N Eat junk food frequently
174: Y N On a special diet
Type _____
175: Y N Vegetarian How long _____
176: Y N Current dietary supplements
List supplements:

Implants / Orthopedic Supports

177: Y N Breast implants
178: Y N Cardiac (pacemaker, etc.)
179: Y N Joint Implants / replacements / braces
Where? _____
180: Y N Other Implants / Supports
(including heel or sole lifts)
Type? _____
181: Y N Pins / Plates / Staples
Where _____

Infant History
(Complete on Children Age 3 and Under)

182: Y N Gestation: _____ Weeks
183: Y N Normal pregnancy
184: Y N Complications during pregnancy
185: Y N Normal delivery
186: Y N Complications at birth
187: Y N C-section
188: Y N Breach delivery
189: Y N Forceps delivery
190: Y N Any drugs at delivery
191: Place of birth ❑ Hospital ❑ Home
❑Birthing center
192: Birth Weight _____ lbs _____ oz.
193: Length _____ inches
At what age did child:
194: Hold head up _____
195: Sit up alone _____
196: Crawl _____
197: Stand _____
198: Walk alone _____
199: Eat solid food _____
200: Was child ❑ Breast fed ❑ Formula fed

201: List any childhood diseases
Disease: Age:
_____
_____
_____
202: List immunizations: Age:
_____
_____
_____
Orthopedic problems
203: Y N Spina Bifida
204: Y N Hip dysplasia
205: Y N Other: _____

Other

206: Y N Anything else you think we need to know about you

INTERN AND FACULTY USE:

Intern: _____ # _____

_____
Intern Signature Date

Patient's Faculty Doctor:_____

Faculty History Review: _____

_____
Faculty Signature Date