Patient Medical History Form page 2

FAMILY MEDICAL HISTORY:

	Diseases known	If deceased, cause of death
Father		
Mother		
Brother/Sister		
Grandparents		

REVIEW OF SYSTEMS:

Please indicate if you are now experiencing any of the following: (Please circle answers.)

Recent weight change	Yes	No	Joint pain	Yes	No
Fever	Yes	No	Joint stiffness or swelling	Yes	No
Fatigue	Yes	No	Muscle pains or cramps	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Chest pain or angina pectoris	Yes	No	Convulsions or seizures	Yes	No
Heart trouble	Yes	No	Chronic or frequent coughs	Yes	No
Palpitation	Yes	No	Spitting up blood	Yes	No
Swelling of feet, ankles or hands	Yes	No	Shortness of breath	Yes	No
Slow to heal after cuts	Yes	No	Burning or painful urination	Yes	No
Bleeding or bruising tendency	Yes	No	Kidney stones	Yes	No
Anemia	Yes	No	Blood in urine	Yes	No
Diabetes	Yes	No	Incontinence	Yes	No
Excessive thirst or urination	Yes	No	Moles that are irritated or bleeding	Yes	No
Very dry, flaking skin	Yes	No	Sores that have not healed	Yes	No
Eye disease or injury	Yes	No	Rash or itching	Yes	No
Blurred or double vision	Yes	No	Change in skin color	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No
Loss of appetite	Yes	No	Change in hair or nails	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No	Snoring	Yes	No
Abdominal pain or heartburn	Yes	No	Sleep apnea	Yes	No
Peptic ulcer (duodenal or stomach)	Yes	No	Sinus problems	Yes	No
Memory loss or confusion	Yes	No	Nasal blockage	Yes	No
Nervousness	Yes	No	Hoarseness	Yes	No
Depression	Yes	No	Difficulty swallowing	Yes	No
Insomnia	Yes	No	Hearing loss or ringing in ears	Yes	No
Thyroid problems	Yes	No	Nose bleeds	Yes	No
			Bleeding gums or mouth sores	Yes	No

If the answer to any of the above is yes, please explain: ______________________________

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Patient Signature ______________________ Nurse/M.A. Signature ______________________

REVIEWED BY DOCTOR ______________________ DATE: ______________________