



# MEDICAL HISTORY & REVIEW OF SYSTEMS Page 1

This form will assist your Doctor in getting the complete health picture of your condition, And assist in determining medication interactions and such.

NAME \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

IS INJURY WORK RELATED? \_\_\_\_\_ HAVE YOU REPORTED IT TO YOUR EMPLOYER? \_\_\_\_\_

IS INJURY FROM AUTO ACCIDENT? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Briefly, how did this occur? \_\_\_\_\_

How long has this been bothering you? (**DURATION**) \_\_\_\_\_ Weeks / months

What is the **QUALITY** of pain like? Sharp, Stabbing, Burning, Tingling, Dull

The **TIMING** of the pain is? Constant Intermittent

On a scale of 1 - 10, with 10 being the worst pain you ever experienced, how would you rate the **SEVERITY** of your pain? \_\_\_\_\_ / 10

## REVIEW OF SYSTEMS: Have you recently had any:

Fever/chills.....	yes no	Shortness of breath .....	yes no	Frequent urination.....	yes no
Unexplained weight loss...	yes no	Wheezing.....	yes no	Anxiety.....	yes no
Night awakening pain.....	yes no	Asthma.....	yes no	Recent depression.....	yes no
Night soaking sweats....	yes no	Frequent sore throats.....	yes no	Recent loss.....	yes no
Weakness.....	yes no	Hearing difficulties.....	yes no	Bleeding disorder.....	yes no
Sensory loss.....	yes no	Diarrhea.....	yes no	Easy bruising.....	yes no
Loss of Coordination.....	yes no	Bloody stools.....	yes no	Environmental Allergies.....	yes no
Dizziness.....	yes no	Constipation.....	yes no	Infectious Disease.....	yes no
Irregular heartbeat.....	yes no	Ulcers.....	yes no	HIV or AIDS.....	yes no
Fluttering in chest.....	yes no	Reflux.....	yes no	Tattoos.....	yes no
Chest pain.....	yes no	Cancer.....	yes no	Claustrophobia.....	yes no

## MEDICAL PROBLEMS: (Hypertension, High Cholesterol, Heart Attack, Diabetes, Asthma, Cancer, Gout, Thyroid, Arthritis)

CIRCLE

PAST SURGICAL HISTORY & DATES: \_\_\_\_\_

MEDICATIONS & DOSAGE: \_\_\_\_\_

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

TOBACCO: \_\_\_\_\_ PK/DAY ALCOHOL: \_\_\_\_\_ / WEEK HEIGHT: \_\_\_\_\_ WEIGHT \_\_\_\_\_  
QUIT: \_\_\_\_\_ YRS AGO

Any of the following hereditary diseases in your family? OBESITY, BLEEDING, HTN, STROKE, OSTEOPOROSIS, PSORIASIS, GOUT, ARTHRITIS, RHEMATOID ARTHRITIS

What treatments have you had thus far for your problem? NSAID'S, Phys Therapy, Pain Meds, X-ray, MRI

What is your activity level? (Play sports—which ones? Drive, work-outs, walking, \_\_\_\_\_  
gardening, do your own groceries, household walking only, Assisted Living Facility)