History and Review of Systems

Todays Date: ____________

(If you require more space please use back of sheet)

Name: ____________________________________ Age: ____________ Marital Status: S M D W
Your Occupation: _______________________________ Number of years married ____________
Primary Care Doctor: ____________________________ Do you want medical records sent to them: Y N

Social History
Do you smoke? Y N Amount: ______________________________
Alcohol intake? Y N Amount: ______________________________
Recreational drug use ? Y N Type/Amount: _________________________

Psychosocial
Have you been a victim of abuse? Physically Y N Emotionally Y N
Do you have any history of: Eating disorders Y N Depression Y N

Personal History
Present method of birth control: ___________________ Last menstrual period: _________________
Number of pregnancies: _________________________ Number of live births: _________________
List any medications and/or supplements you are currently using: _____________________________
____
Are you allergic to any medications? ____
Are you allergic to latex? Y N
Previous surgeries: Type: ____________________ Year: __________ MD: __________________
Type: ____________________ Year: __________ MD: __________________
Type: ____________________ Year: __________ MD: __________________

When did you have your last Pap smear? __________ Do you have a history of abnormal Pap Y N
Have you ever been treated for sexually transmitted diseases? Y N Type: _____________________
Have you had a mammogram? Y N Date: _______________________________
Have you had a bone density study? Y N Date: _______________________________

Current health concerns: ____

Patient & Family History Please check if you have a history of the following:

Patient History

- ☐ Arthritis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Stomach Problems
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Seizure Disorder
- ☐ Blood Disorder
- ☐ Osteoporosis
- ☐ Cancer/Type ____________________________
- ☐ Urinary Incontinence
- ☐ Burning with urination
- ☐ Frequent Urination
- ☐ Blood in your Urine
- ☐ Frequent Thirst
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Black Stools
- ☐ Recurrent Headaches
- ☐ Visual Problems
- ☐ Pulmonary Embolism
- ☐ Hepatitis

Family History

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Stomach Problems
- ☐ Diabetes
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Seizure Disorder
- ☐ Blood Disorder
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Cancer/Type _____________

Patient Signature: ____ Date: _______________ IN _____

Provider/Medical Staff Signature: ____________________________ Date: ______________________