Medical History

Review of Systems (ROS)

Please check mark Yes or No to any of the following below

Constitutional	**Y**	**N**	**Ear/Nose/Throat**	**Y**	**N**	**Eyes**	**Y**	**N**
Chills/fevers			Hearing Loss			Glasses/contacts		
Fatigue			Sinus problems			Blurry/double vision		
Night Sweats			Nose bleeds			Eye disease/injury		
Weight loss			Sore throat			Glaucoma		
Cardiovascular	**Y**	**N**	**Respiratory**	**Y**	**N**	**Hematology**	**Y**	**N**
Chest pain			Shortness of breath			Anemia		
Irregular heartbeat			Cough			Easy bleeding		
Feet/hand swelling			Wheezing			Swollen glands/Nodes		
Heart trouble			Coughing up blood			Slow to heal		
Musculoskeletal	**Y**	**N**	**Endocrine**	**Y**	**N**	**Allergy/Immunologic**	**Y**	**N**
Back pain			Excessive thirst			Food allergies		
Joint pain			Hormone problems			Aspirin allergies		
Stiffness/Swelling joints			Thyroid disease			Antibiotic allergies		
Muscle cramps/pain			Heat/Cold intolerance			Seasonal allergies		
Genital - Female	**Y**	**N**	**Genital - Male**	**Y**	**N**	**Integumentary**	**Y**	**N**
Painful periods			Testicular pain			Change in hair/nails		
Sexual dysfunction			Sexual dysfunction			Rash/Itching		
Birth Control use			Difficult urination			Breast lump/pain		
Blood in urine			Prostate problems			Dry skin		
Psychiatric	**Y**	**N**	**Neurological**	**Y**	**N**	**Gastrointestinal**	**Y**	**N**
Insomnia			Convulsions/Seizures			Nausea/Vomiting		
Confusion/memory loss			Dizziness/Fainting			Reflux/Heartburn		
Anxiety			Muscle weakness			Constipation		
Depression			Headaches			Rectal bleeding		
Bipolar			Numbness/tingling			Abdominal pain		
	Y	**N**		**Y**	**N**		**Y**	**N**
High Blood Pressure			Stroke			Kidney disease/stones		
High Cholesterol			Diabetes			Cancer		
Heart Attack			Liver Disease			Type:		
HIV/AIDS			Asthma			Other:		
Skin disease			Autoimmune disease					

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

Surgical History:

	Y	N		Y	N		Y	N
Appendix Removal			Bladder surgery			C-sections		
Gallbladder surgery			Prostate surgery			Hernia repair		
Back surgery			Open heart surgery			Other:		
Hysterectomy			Cardiac Catheterization					
Breast Surgery			Cataract surgery					

Allergies: □ **No Known Drug Allergies**

_____

_____

Hospitalizations in the last year:

_____

_____

Medications:

Name of medication	Dosage & frequency	Reason for taking

Family History:

Mother: _____

Father: _____

Grandmother: _____

Grandfather: _____

Son: _____

Daughter: _____

Siblings: _____

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

Social History:

Have you ever smoked? □ Yes □ No

• If you stopped smoking when did you quit? _____

• If yes, number of years? _____

• If you currently smoke, how many packs per day? _____

• Do you use smokeless tobacco? (i.e. chewing tobacco) □ Yes □ No

Do you drink alcohol? □ Yes □ No

• If yes, how much a week? _____

Do you currently use recreational drugs? □ Yes □ No

• If yes, which drugs? _____

Are you on a special diet? □ Yes □ No

• If yes, please describe: _____

Do you exercise? □ Yes □ No

• If yes, what type and how often? _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Occupation: _____

What was the date of your last Flu vaccine? (Month/Year) _____/_____

Did you get the COVID 19 vaccine? □Yes □ No

Female ONLY:

Date of Last Menstrual Period: ____/____/_____ Number of pregnancies: _____

Complications in pregnancy (e.g. diabetes, high blood pressure, protein in urine): □ Yes □ No

_____ _____ ____/____/_____

Patient Name **Signature** **Date**