PATIENT HISTORY
AND
REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY.
(This information will be included in your chart)

REVIEW OF SYMPTOMS:

YES	NO	
____	____	1. Constitutional problems such as fever, weight loss, etc.
____	____	2. Eye problems
____	____	3. Ears, nose and throat
____	____	4. Cardiovascular (heart or circulatory)
____	____	5. Respiratory
____	____	6. Gastrointestinal
____	____	7. Genito-urinary and reproductive
____	____	8. Musculo-skeletal
____	____	9. Endocrine
____	____	10. Skin and breast
____	____	11. Hematologic / lymphatic
____	____	12. Allergic / immunologic
____	____	13. Psychiatric or emotional

FAMILY HISTORY: (especially hereditary and environmental factors)

SOCIAL HISTORY: (past and current activities)

PAST MEDICAL HISTORY: (previous illnesses, treatments and surgery)

LIST OF CURRENT MEDICATIONS: (frequency and dosage)

DRUG ALLERGIES: