

System Review and Past Medical History

Name: _____

From the following list, please check any symptoms or conditions that apply to you.

SKIN

- Rashes, psoriasis or dermatitis
- History of skin cancer
- New skin growth or mole

EYES

- Wear glasses
- Wear contact lenses
- Permanent blindness in either eye
- Cataracts
- Glaucoma

EARS / NOSE / THROAT

- Loss of hearing
Hearing aids? Yes No
- Ringing in the ears
- Frequent ear aches
- Discharge from the ear
- Attacks of vertigo
- Frequent sinus infections
- Nasal blockage
- Frequent sneezing
- Frequent sore throat
- Loud snoring
- Recent change in voice quality
- Sleep apnea
- Difficulty in swallowing
- Frequent headache
- Nose bleeds
- Exposure to loud noise

RESPIRATORY

- Asthma or wheezing
- Recent bronchitis or chest cold
- Cough for over the past 2 months
- Coughing up blood
- Shortness of breath

HEART & CIRCULATION

- Heart attack
- Hypertension (high blood pressure)
- Heart murmur
- Chest discomfort (angina) with physical activity
- Heart failure or fluid on the lungs
- Palpitations, racing or pounding heart beat
- Stroke
- Blood clot in artery or vein
- "Mini-strokes" or TIA's
- "Black out spells"
- Aneurysm of any blood vessel
- Frequent ankle swelling at bedtime
- Heart surgery

STOMACH / INTESTINES

- Stomach ulcer or peptic ulcer
- Frequent heartburn or indigestion
- Hiatal hernia and or acid reflux
- Poor appetite
- Gall bladder attacks
- Frequent diarrhea
- Chronic constipation
- Bright blood from bowels or rectum
- Dark, tarry stools
- Liver disease or jaundice

ENDOCRINE / METABOLISM

- Thyroid disorder
- Recent weight gain or loss (More than 10 lbs.)
- Diabetes

KIDNEYS / URINARY TRACT

- Kidney disease or failure
- History of kidney dialysis
- Kidney stones or infection
- Pain or burning with urination
- Trouble starting urinary stream
- Dribbling or incontinence
- Multiple trips to the bathroom to urinate at night
- Bladder infections during past year
- Blood in urine during past year
- Prostate disease

MUSCLES / BONES / JOINTS

- Arthritis or other joint disease
- Chronic back trouble
- Bone or joint surgery in past year

NERVOUS SYSTEM

- Migraine headaches
- Epilepsy or seizures
Date of last seizure: _____
- Depression
- Other nervous disorder
Specify: _____

BLOOD

- Bleeding or bruising tendency
- Previous blood transfusion
- History of hepatitis

REPRODUCTIVE (Women only)

- Are you or might you be pregnant?
 Yes No

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): _____

Do you have any other special concerns or additional information that we should be aware of regarding your care?

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____

Date: _____

Physician review: George B. Stoneman, M.D. _____ Richard W. Clark, M.D. _____ Leah E. Mintz, M.D. _____