

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name _____

Date _____

Date of Birth _____ Male Female

Spouse\Significant Other _____

SOCIAL HISTORY:

Birthplace _____

Your Occupation _____

Nationality _____

Education _____

Religion _____

Marital Status _____ How many years _____

Drug Use _____

Children _____

Tobacco Use Yes No Type _____

Packs per day _____ for _____ years Quit _____

Alcohol Use _____

Drinks _____ per day week month

Pets _____

Exercise (type/how often?) _____

Recent or Frequent Travel Destinations _____

If heavy use, how many years _____ Quit _____

Caffeine (coffee, tea, soda, chocolate) Servings per day _____

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Heart Attack/Coronary | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Artery Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hives | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Positive TB Skin Test | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Head Injury | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Broken Bones | |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> Blood transfusions | IMMUNIZATIONS: |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent Bladder Infection | <input type="checkbox"/> Sexually Transmitted Diseases: Herpes, HIV, | <input type="checkbox"/> Measles, Mumps and Rubella Vaccine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Gonorrhea, Chlamydia, | <input type="checkbox"/> Chicken pox vaccine |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hepatitis B vaccine |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Intravenous drug abuse | <input type="checkbox"/> Influenza vaccine |
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Needle injury | <input type="checkbox"/> Pneumococcal vaccine |
| <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus booster |
| <input type="checkbox"/> Heartburn / Reflux | <input type="checkbox"/> Anemia | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Sinus Infections | | |
| <input type="checkbox"/> Seizures | | | |

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- | | | |
|---|--|--|
| <input type="checkbox"/> Eyes (Laser or Vision Corrected) _____ | <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Spinal Surgery/Back _____ |
| <input type="checkbox"/> Eyes (Cataract/Glaucoma) _____ | <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Orthopedic (Hips/ Knee) _____ |
| <input type="checkbox"/> Ears _____ | <input type="checkbox"/> Intestine/Colon _____ | <input type="checkbox"/> Shoulder/ Feet/Hands) _____ |
| <input type="checkbox"/> Sinus/Nasal Septum _____ | <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> C-section _____ |
| <input type="checkbox"/> Tonsils/Adenoid _____ | <input type="checkbox"/> Hernia _____ | |
| <input type="checkbox"/> Thyroid _____ | <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Vasectomy _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Uterus/Hysterectomy _____ | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Stomach _____ | <input type="checkbox"/> Ovaries _____ | |
| <input type="checkbox"/> Varicose Veins _____ | <input type="checkbox"/> Spinal Surgery/Neck _____ | |
| | <input type="checkbox"/> Prostate _____ | <input type="checkbox"/> OTHER _____ |

ALLERGIES and Bad Reactions to Medications:

MEDICATIONS:

Name

Dosage

Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Has anyone in your FAMILY ever had? **(If yes check box and list relationship)**

<input type="checkbox"/> Cancer & Type _____	<input type="checkbox"/> Dialysis _____	<input type="checkbox"/> Crohn's/colitis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Chronic lung disease _____	<input type="checkbox"/> Alzheimer's _____
<input type="checkbox"/> Cardiac Dysrhythmia _____	<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Alcoholism _____
<input type="checkbox"/> Congestive Heart Failure _____	<input type="checkbox"/> Rheumatoid Arthritis _____	<input type="checkbox"/> Bleeding tendency _____
<input type="checkbox"/> Coronary Artery Disease _____	<input type="checkbox"/> Thyroid trouble _____	<input type="checkbox"/> Anemia _____
<input type="checkbox"/> Valvular heart Disease _____	<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Gout _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Cystic Fibrosis _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Mental illness _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Peptic Ulcer _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Kidney stones _____	<input type="checkbox"/> Gallstones _____	<input type="checkbox"/> Migraine headaches _____
<input type="checkbox"/> Kidney disease _____		
<input type="checkbox"/> OTHER _____		

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Age when you Started Menstruating? _____ Number of Pregnancies? _____

Date of Last PAP? _____ Number of Births? _____

History of abnormal Pap's Yes / No (Please circle) Vaginal / C-section (Please Circle)

Date of Last Mammogram? _____ Method of Contraception _____

History of Abnormal Mammograms Yes / No (Please circle)

Menstrual Cycles? Regular / Irregular (Please Circle)

Pain with Periods? Yes / No (Please Circle)

Age at Menopause? _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL

- Fatigue
- Fever
- Weight Gain >10 pounds
- Weight Loss >10 pounds

SKIN

- Nail Changes
- New Lesions
- Rash
- Skin Color Changes

HEENT

- Double Vision
- Eye Pain
- Eye Redness
- Decreased Hearing
- Earache
- Ear Ringing
- Nose Bleeds
- Dry Mouth
- Hoarseness
- Oral Ulcers
- Sore Throat

NECK

- Neck Pain
- Swollen Glands

RESPIRATORY

- Chronic Cough
- Decreased Exercise Tolerance
- Difficulty Breathing
- Coughing Up Blood
- Sputum Production
- Wheezing

BREAST

- Breast Mass
- Breast Pain
- Nipple Discharge
- Skin Changes

CARDIOVASCULAR

- Chest Pain
- Leg Pains with walking
- Leg Swelling
- Night Awakening due to trouble Breathing
- Palpitations
- Shortness of Breath

GASTROINTESTINAL

- Abdominal Pain
- Change in Bowel Habits
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Rectal Bleeding
- Trouble Swallowing

GENITOURINARY

- Vaginal Discharge
- Menstrual Irregularities
- Difficulty Starting/Stopping urinary Stream
- Painful Urination
- Change in Urinary Stream
- Increased Frequency
- Blood in Urine
- Loss of Bladder Control
- Nighttime Urination
- Urinary Retention
- Urethral Discharge
- Impotence
- Penile Lesions
- Testicular Mass
- Testicular Pain

MUSCULOSKELETAL

- Decreased Range of Motion
- Joint Pain
- Joint Redness
- Joint Swelling
- Joint Stiffness
- Muscle Wasting
- Muscle Weakness
- Muscle Aches/Pains

NEUROLOGICAL

- Loss of Bowel Control
- Dizziness/Vertigo
- Headaches
- Numbness/Tingling
- Passing Out
- Seizures
- Tremor

PSYCHIATRIC

- Anxiety
- Change in Sleep Pattern
- Depression
- Hallucinations
- Suicidal Thoughts

ENDOCRINE

- Appetite Changes
- Cold Intolerance
- Increased Thirst
- Increased Urination
- Hair Changes
- Sexual Dysfunction

HEMATOLOGY

- Easy Bruising
- Enlarged Lymph Nodes
- Prolonged Bleeding