NAME______________________ AGE______________ DATE______

SYSTEMATIC REVIEW
RESPIRATORY(CON'T)

Asthma or Wheezing....................No Yes
Difficulty breathing.......................No Yes
Any trouble with Lungs..................No Yes
Pleurisy or Pneumonia........ ....No Yes

Cardiovascular

Chest Pain or angina pectoris..........No Yes
Shortness of Breath when walking or
Laying down................................ No Yes
Difficulty walking two blocks..........No Yes
Heart Trouble/attacks.....................No Yes
High blood pressure.................. No Yes
Swelling of hands, feet or ankles.......No Yes
Awakening in night smothering..........No Yes
Heart murmur..............................No Yes

Gastrointestinal

Peptic ulcer..................................No Yes
Vomiting blood or food....................No Yes
Gallbladder disease..........................No Yes
Liver trouble.................................No Yes
Hepatitis......................................No Yes
Painful bowel movements................No Yes
Bleeding in bowel movements.........No Yes
Black stools.................................No Yes
Hemorrhoids or piles......................No Yes
Recent change in bowel habits............No Yes
Frequent diarrhea............................No Yes
Heartburn or indigestion...................No Yes
Cramping or pain in abdomen.............No Yes
Does food stick in throat....................No Yes

Genitourinary

Loss of urine.................................No Yes
Frequent urination...........................No Yes
Night time urinating..........................No Yes
Burning or painful urination.................No Yes
Blood in urine.................................No Yes

Gynecological

Age periods started__________________
How long do periods last?__________________

Gynecological (Con't)

Number of Pregnancies................__________
Number of miscarriages...............__________
Date of Last Pap Smear...............__________
Pap smear results__________________
Frequency of Periods every, __________Days
Any Pain with Periods No Yes
Number of Children _____Ages_____________
Date of last period__________________

Locomotor-Musculoskelal

Varicose veins..............................No Yes
Weakness of muscle or joints.........No Yes
Any difficulty when walking..........No Yes
Any pain in calves or buttocks........No Yes
relived by resting.........................No Yes

Neuro-Psychiatric

Have you ever had psychiatrist care?........No Yes
Do you ever have, or have had fainting spell____
Convulsion...................................No Yes
Paralysis.....................................No Yes

Hematological

Are you slow to heal after cuts.............No Yes
Blood disease..................................No Yes
Anemia...No Yes
Phlebitis..No Yes
Have you had difficulty with bleeding excessively
after tooth extraction or surgery No Yes
Have you had abnormal bruising
or bleeding?...................................No Yes

Allergic

Any allergies, including medication......No Yes

Endocrine

Thyroid disease...............................No Yes
Hormone therapy.............................No Yes
Any change in hat or glove size.............No Yes
Any change in hair growth....................No Yes
Have you become colder than before
or skin become dryer...................No Yes

Allergies and Sensitivities

Is there any history of skin reaction or other untoward reaction of sickness following injection or oral administration: (Circle One?)

PENICILLIN OR OTHER ANTIBIOTIC..NO YES
MORPHINE,CODEINE,DEMORAL OR OTHER MEDICATIONS.........................NO YES
NOVOCAIN OR OTHER ANESTHETICS..NO YES
ASPIRIN,EMPIRIN OT OTHER PAIN REMEDIES...NO YES
SULFA DRUGS..NO YES
TETANUS ANTITOXIN OR OTHER SERUMS..NO YES
ADHESIVE TAPE...NO YES
IODINE OR MERTHIOLATE..NO YES
ANY OTHER DRUG MEDICATION..NO YES
ANY FOODS, SUCH AS EGG, MILK OR CHOCOLATE......................................NO YES

DRUG RECENTLY TAKEN: WITHIN THE PAST SIX MONTHS HAS THE PATIENT TAKEN

ASPIRIN................................NO YES
CORTISONE...........................NO YES
ACTH....................................NO YES
ANTICOAGULANTS................NO YES
TRANQUILIZERS...................NO YES

HYPOTHESIVES................NO YES
HAS THE PATIENT EVER RECEIVED TREATMENT
FOR ASTHMA, RHEUMATISM OR RHEUMATIC
FEVER.....................NO YES

SIGNATURE OF PERSON PROVIDING INFORMATION IF OTHER THAN PATIENT__________________

HEALTH QUESTIONAIRE

NAME______________________ AGE__________ DOB____________ TODAYS DATE____________

HISTORY OF PAST ILLNESS: Have you had

Childhood

Measles..........No Yes	Stokes..........No Yes	Rheumatic fever or heart disease..........No Yes
Mumps..........No Yes	Cancer..........No Yes	Congenital Abnormalities..........No Yes
Chickenpox..........No Yes	Tuberculosis..........No Yes	Other serious disease..........No Yes
Diabetes..........No Yes	Venereal Disease...No Yes	

Adult

Have you had any serious illness..........No Yes
Have you ever been hospitalize or been under medical care for a long time..........No Yes
If YES, for what reason?______________________

Operations

Have you had any surgery..........No Yes
List sugeries______________________

Injuries

Have you had any broken bones..........No Yes
Have you had any head concussions or injuries..........No Yes
Have you ever been knocked unconscious..........No Yes

FAMILY HISTORY

Has any blood relative have or ever had:

	MOTHER	FATHER	BROTHER/SISTER
CANCER			
TUBERCULOSIS			
DIABETES HEART TROUBLE			
HYPERTENSION			
STROKE			
CONVULSIONS			
SUICIDE			
MENTAL ILLNESS			
BLEEDING TENDENCY			
GOUT OR OTHER ARTHRITIS			
HEREDITARY DEFECTS			

SOCIAL HISTORY

CIRCLE ONE: Single Married Separated Divorce Widowed
Are you living with you husband or wife..........No Yes
Do you have any dependants living at home..........No Yes
Alcoholic Beverages ....Never______ Rarely______ Moderatly______ Daily______ Ever______
Do You smoke..........No Yes
If yes how many cigarettes or packs per day______________
Are you employed? Full Time________ Part Time________
What is your job______________________
Are you exposed to fumes, dusts or solvents?______________________

Systemic Review

General
Recent weight change..........No Yes
Have you been in good health most of your life ..No Yes

Skin

Skin disease..........No Yes
Jaundice..........No Yes
Hives,eczema or rash..........No Yes
Frequent infection or boils..........No Yes
Abnormal pigmentation..........No Yes

Head, Eyes, Ears, Nose, Throat

Eye disease or injury..........No Yes
Do you wear glasses?..........No Yes
Double vision..........No Yes
Headaches..........No Yes
Glaucoma..........No Yes

Head, Eyes, Ears, Nose, Throat (con't)

Sneezing or runny nose..........No Yes
Nosebleeds..........No Yes
Chronic sinus trouble..........No Yes
Ear disease..........No Yes
Impaired Hearing..........No Yes
Dizziness or transit episodes of unconsciousness. No Yes

Neck

Stiffness..........No Yes
Thyroid trouble..........No Yes
Enlarged glands..........No Yes

Respiratory

URI (cold) now..........No Yes
Spitting up blood..........No Yes
Chronic or frequent cough ....No Yes