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.

Today's Date_____

Last Name: _____ First Name: _____

Date of Birth_____ ☐ Male ☐ Female Marital Status: _____

SOCIAL HISTORY:

Birthplace_____

Nationality_____

Religion_____

Education Level: _____

Your Occupation: _____

Marital Status: _____

How many years?_____

Number of Children?_____

Number of Pets?_____

Tobacco Use ☐ Yes ☐ No

If yes, have you Quit? ☐ Yes ☐ No

If yes, What Type _____

Packs per day_____for_____ Months _____Years

Alcohol Use ☐ Yes ☐ No

If yes, have you Quit? ☐ Yes ☐ No

Drinks_____per ☐ day ☐ week ☐ month

Drug Use_☐ Yes ☐ No

If yes, have you Quit? □ Yes □ No

If yes, What Type _____

Caffeine (coffee, tea, soda, chocolate) Servings per day_____

How often do you exercise? _____per ☐ day ☐ week

Recent or Frequent Travel? ☐ Yes ☐ No

If Yes, Where: _____

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

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

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

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

ALLERGIES and Bad Reactions to Medications: ☐No Known Allergies

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS:

Name	Dosage	Number of Times a Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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

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

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Method of Contraception _____

Age when you Started Menstruating?_____

Date of Last PAP? _____

History of abnormal Pap's ☐ Yes ☐ No

Date of Last Mammogram? _____

Menstrual Cycles? ☐ Regular ☐ Irregular

Pain with Periods? ☐ Yes ☐ No

Age at Menopause?_____

Number of Pregnancies? _____

Number of Births?_____

☐ Vaginal # OF _____ ☐ C-section # OF _____

History of Abnormal Mammograms ☐ Yes ☐ No

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
☐ Sleep Apnea
☐ C-Pap Machine?
☐ Yes ☐ No

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

☐ Other: _____

_____