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Direction of Feed

Medical History & Review of Systems

Please answer every question

STAFF: Handwritten items must be entered **MANUALLY**.
Fold only on dotted lines.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

SOCIAL HISTORY

What is your marital status?
- single
- partnered
- divorced
- married
- separated
- widowed

Who lives in your household with you?
- live alone
- sibling(s)
- roommate(s)
- spouse / partner
- child(ren)
- assisted living
- parent(s)
- grandparent(s)
- campus housing

How many children do you have?
0 1 2 3 4 5 6 7 8 9 10 11+

Do you have any of the following?
- pacemaker
- metal in body (where): ______
- NONE
- hearing aid

please fold on dotted line

What is your occupation? ______

Do you drink alcohol? yes / no / in the past

If yes, how many drinks per week? occasionally / 1 – 3 / 4 – 7 / 8 – 14

Do you exercise? yes / no

If yes, how many times per week? occasionally / 1 – 3 / 4 – 7 / 8 – 14

REVIEW OF SYSTEMS

Please indicate if you CURRENTLY are experiencing any of the following.
If you have no symptoms in a category, please mark NONE.

GENERAL
- sweats
- weight loss
- chills
- appetite loss
- fevers
- fatigue (always tired)
- NONE

EYES
- blurring
- vision loss (1 eye)
- discharge
- vision loss (both eyes)
- eye irritation
- NONE

EARS / NOSE / THROAT
- decreased hearing
- difficulty swallowing
- NONE

CARDIOVASCULAR
- chest pain / discomfort
- palpitations
- racing / skipping heartbeats
- weight gain
- shortness of breath with exertion
- blackouts / fainting
- difficulty breathing while lying down
- swelling of hands / feet
- NONE

RESPIRATORY
- shortness of breath
- wheezing
- cough
- coughing up blood
- NONE

please fold on dotted line

GASTROINTESTINAL
- vomiting
- diarrhea
- nausea
- NONE

GENITOURINARY
- pain
- urinary retention
- frequent UTI (urinary tract infection)
- NONE

MUSCULOSKELETAL
- joint swelling
- back pain
- joint pain
- arthritis
- muscle aches
- stiffness
- muscle cramps
- loss of strength
- muscle weakness
- gout
- NONE

SKIN
- dryness
- psoriasis
- suspicious lesions
- changes in color of skin
- poor wound healing
- unusual hair distribution
- NONE

Continued on next page...

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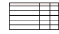

REVIEW OF SYSTEMS continued

NEUROLOGIC

- ◯ headaches
- ◯ weakness
- ◯ numbness
- ◯ tingling
- ◯ poor balance
- ◯ seizures
- ◯ tremors
- ◯ disturbances in coordination
- ◯ visual disturbances
- ◯ falling down
- ◯ memory loss
- ◯ NONE

PSYCHIATRIC

- ◯ anxiety
- ◯ depression
- ◯ NONE

HEME / LYMPHATIC

- ◯ abnormal bruising
- ◯ NONE

ALLERGIC / IMMUNOLOGIC

- ◯ seasonal allergies
- ◯ persistent infections
- ◯ NONE

ALLERGIES

please fold on dotted line

◯ **I have no known medication allergies.**

Are you allergic to any of the following? (Please list any reactions that you have.)

Allergen:	Reaction:	Allergen:	Reaction:
◯ latex		◯ betadine / iodine	
◯ tape		◯ sulfa	
◯ contrast dye		◯ metal(s)	
◯ shellfish / seafood		◯ novocain	
◯ PCN (Penicillin)			

OTHER (please include reaction): ____________________

MEDICAL HISTORY

Please indicate if you have had any of the following conditions:

- ◯ Anemia
- ◯ Anesthesia Problems
- ◯ Arthritis
- ◯ Asthma
- ◯ Birth Defect
- ◯ Bleeding Disease
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Lung Cancer
- ◯ Lupus
- ◯ Mitral Valve Prolapse

please fold on dotted line

- ◯ Blood Clots
- ◯ Breast Cancer
- ◯ Bruise Easily
- ◯ Colon / Rectal Cancer
- ◯ COPD / Emphysema
- ◯ Depression
- ◯ Diabetes
- ◯ Fibromyalgia
- ◯ Heartburn
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ MRSA
- ◯ Neuropathy
- ◯ Osteoporosis
- ◯ Polio
- ◯ Prostate Cancer
- ◯ Seizure Disorder
- ◯ STD (Sexually Transmitted Disease)
- ◯ Stomach Ulcers
- ◯ Stroke
- ◯ TB (Tuberculosis)
- ◯ Thyroid Disease
- ◯ **Other Cancer**
- ◯ **Other Connective Tissue Disorder**
- ◯ **Other Illness**
- ◯ **NO SIGNFICANT MEDICAL HISTORY**

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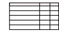
Direction of Feed

Medical History & Review of Systems

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****. Fold only on dotted lines.*



SURGERIES

Please indicate if you have had any of the following surgeries:

- ◯ Adenoidectomy
- ◯ Appendectomy
- ◯ Cancer Surgery
- ◯ Carotid Artery
- ◯ Ear Tubes
- ◯ Gallbladder
- ◯ Gastric Bypass
- ◯ Heart Bypass
- ◯ Hernia
- ◯ Stomach Ulcer
- ◯ Thyroid
- ◯ Tonsillectomy

	Left	Right	Both
Kidney Removal	◯	◯	◯
Ovary Removal	◯	◯	◯
Breast Cancer Lump Removal	◯	◯	◯
Mastectomy	◯	◯	◯
Lung	◯	◯	◯
Foot	◯	◯	◯
Kyphoplasty	◯	◯	◯
Arthroscopic Shoulder	◯	◯	◯
Hip Fracture	◯	◯	◯
Total Hip Replacement	◯	◯	◯
Total Knee Replacement	◯	◯	◯
Arthroscopic Knee	◯	◯	◯
Total Shoulder Replacement	◯	◯	◯
Hand	◯	◯	◯

please fold on dotted line

OTHER (please specify):

____

____

____

____

____

	TURP	Removal
Prostate	◯	◯

	Total	Partial
Colon Removal	◯	◯
Hysterectomy	◯	◯

	Single	Multiple
Vein Stripping	◯	◯
Leg Circulation	◯	◯

	Neck	Lower Back
Spinal Fusion	◯	◯

◯ **I have had NO SURGERIES**

FAMILY MEDICAL HISTORY

Please indicate which family members have had these conditions:

◯ **Family History UNKNOWN** ◯ **NONE**

please fold on dotted line

	Father	Mother	Brother	Sister
Diabetes	◯	◯	◯	◯
Lung Disease	◯	◯	◯	◯
Drug Abuse	◯	◯	◯	◯
Back Problem	◯	◯	◯	◯
Cancer	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯
Malignant Hypothermia	◯	◯	◯	◯
Depression	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯
Stroke	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯

OTHER (please specify condition and family member): ____

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