

Name _____

Age _____

Date _____

Reason for today's visit: (chief complaint)

Medical History and Systems Review

Have you had problems with any of the following?(Check all that apply)

	No	Current	Past	Please explain
General Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females only: Currently pregnant Abnormal periods Yeast infections On birth control
 Planning pregnancy Breast feeding

Do you take blood thinner or aspirin? Yes No

Cancer(s): (List Type, Date, Treatment) _____

Current Medications: _____ Medication Allergies: (Circle) NONE Sulfur Penicillin
 Lidocaine Codeine Tetracycline Band-aids
 Others: (list) _____

Family History

Check the following medical conditions that have occurred in your family:

	Mother	Father	Blood Relative	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____

Social History: Do you live alone? No Yes Do you smoke? No Yes- how much? _____
 Do you drink alcohol? No Yes-amount? _____ Do you use recreational drugs? No Yes-frequency _____
 Occupation _____ Hobbies/leisure activities _____
 How much time do you spend: in the sun? _____ Tanning bed? _____

MA initials: _____ Date: _____
 Reviewed: _____ Date: _____