Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS FORM

PAST ILLNESSES OF PATIENT AND IMMEDIATE FAMILY

	Patient	Family		Patient	Family
Anemia	□	□	Arthritis	□	□
Asthma	□	□	Stroke	□	□
Cancer/Tumors	□	□	Thyroid Disease	□	□
Diabetes	□	□	Infectious Diseases	□	□
Depression	□	□	GI Disease	□	□
Epilepsy/Seizures	□	□	High Cholesterol	□	□
Heart Disease	□	□	HIV/Immune Disease	□	□
High Blood Pressure	□	□	Lung Disease	□	□
Liver Disease	□	□	Kidney Disease	□	□
Hepatitis	□	□	Other	□	□

Current Medicines:_____

Allergies:_____

Past Surgeries/Hospitalizations: _____

Reason for visit:_____

Has your child received immunizations? _____Is he/she current on immunizations? _____

REVIEW OF SYMPTOMS-CHECK ANY ITEM THAT APPLIES TO PATIENT'S CURRENT HEALTH:

General:
Weight loss ___
Fever ___
Fatigue ___

Allergies:
Hives/Eczema ___
Hay Fever ___
Food ___

Eyes:
Glasses ___
Blurred vision ___
Eye pain ___
Eye discomfort ___

Skin:
Rashes ___
Sore ___
Itching/burning ___

Cardiovascular:
Heart Murmur ___
Irregular heart beat ___
Chest pains ___
Fainting spells ___

ENT:
Ear pain ___
Nosebleeds ___
Sore throat ___
Hoarseness ___
Nasal stuffiness ___

Endocrine:
Thyroid problems ___
Loss of hair ___
Heat/cold intolerance ___
Poor growth ___

Genitourinary:
Pain with urination ___
Blood in urine ___
Increased urine frequency ___
Abnormal discharge ___

Neurological:
Headaches ___
Seizures ___
Dizziness ___
Developmental delays ___

Gastrointestinal:
Blood in stool ___
Vomiting ___
Abdominal pain ___
Constipation ___
Heartburn ___

Respiratory:
Cough ___
Wheezing ___
Shortness of breath ___
Apnea ___

Hematology:
Bleeding problems ___
Anemia ___
Easy bruising ___
Enlarged Glands ___

Musculoskeletal:
Joint pain/swelling ___
Weakness ___
Muscle pain ___