MEDICAL HISTORY AND REVIEW OF SYSTEM

Patient's name _____ **Age**_____**Weight** _____**Height**_____ **Shoe size** _____

CIRCLE MEDICAL CONDITION:

If you have **no** medical condition circle: **NONE**

** ANY RECENT FALLS IN THE PAST 12 MONTHS? YES____ NO____

*** FEMALE ONLY** PREGNANT YES NO
BREAST FEEDING YES NO

VACCINES **FLU** shot date _____ **PNEUMONIA** shot date_____
SHINGLES_____ **COVID -19** Yes No - Pfizer Moderna J&J

CARDIAC: HEART ATTACK PACEMAKER A-FIB
MURMUR PALPITATIONS HYPERTENSION
ANGINA CHF HIGH CHOLESTEROL
INTERMITTENT CLAUDICATION STENT(S)
ARRHYTHMIAS CVA(STROKE)
OTHER_____

RESP: ASTHMA BRONCHITIS SNORING COUGH
S.O.B PNEUMONIA EMPHYSEMA
COPD SLEEP APNEA
*COVID 19 -Dx. date_____

ENDO:
DIABETES **INSULIN DEP** **NON INSULIN**
* Dx. date_____ *** HBA1C**_____
BLOOD SUGAR _____**FASTING: Y___ N___**
GOUT THYROID (Hypo or Hyper) OBESITY
OSTEOPOROSIS

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS - HIV LYMPHEDEMA

ANTICOAGULANT THERAPY_____
**Aspirin, Clopidogrel, Eliquis, Coumadin, Xarelto, Pradaxa

RENAL: PROSTATE DIALYSIS POLYURIA HEMATURIA
KIDNEY DISEASE URINARY TRACT INF.
HEPATITIS JAUNDICE

GASTRIC: ULCER REFLUX GASTRITIS
DIARRHEA CONSTIPATION
OTHER_____

PAST SURGICAL HISTORY * NONE

MEDICATIONS: *NONE

FAMILY HISTORY:
PARENTS: FATHER: DIABETES, HIGH BLOOD PRESSURE
CANCER HEART DISEASE
MOTHER: DIABETES, HIGH BLOOD PRESSURE
CANCER HEART DISEASE

EENT: GLASSES CONTACTS
GLAUCOMA CATARACTS
BLURRED VISION
VERTIGO HEARING AIDS
SINUSITIS DIFFICULTY SWALLOWING
OTHER_____

SKIN: DERMATITIS ACNE ECZEMA
SKIN CANCER TINEA
ONYCHOMYCOSIS PSORIASIS
WART(S) OTHER_____

NEURO: SEIZURE EPILEPSY
ALZHEIMER'S PARKINSON'S
MIGRANES WEAKNESS
DIZZINESS PARALYSIS
ADHD ADD AUTISM
OTHER_____

PSYCH: DEPRESSION PSYCH PROBLEMS
ANXIETY OTHER_____

SKELETAL: ARTHRITIS LUPUS
PAIN: BACK NECK KNEE
ANKLE FEET HAND
PAST FRACTURES:_____
_____

PATIENT'S CANCER: YES_____NO_____

HISTORY: _____

ALLERGIES:
DRUGS:_____
FOODS:_____
OTHER: _____

SOCIAL HISTORY:
OCCUPATION: _____
ACTIVITIES: Running, Walking, Hiking, Swimming, Yoga, Golf
OTHER _____
ALCOHOL: NONE_____SOCIALLY_____
SMOKING: YES___ NO___ STOPPED ___WHEN?_____
HOW MUCH DO YOU SMOKE?_____
DRUGS: _____
LIVES WITH: Alone Spouse Child/Children
Parent(s) Roomate Other
ADD'N INFO _____