PATIENT HISTORY AND SYSTEMS REVIEW FORM

PATIENT NAME: ____ DATE OF BIRTH: _____/_____/_____

FAMILY HISTORY: Has anyone in your family ever had or presently have any of these problems (include mother, father, grandmother, grandfather, brothers, sisters, etc) Please specify relationship

Allergies________________________ Diabetes________________________ Alcoholism __________________________

Asthma ________________________ Thyroid Disease__________________ Drug Abuse__________________________

High Blood Pressure______________ Cancer__________________________ Birth Defects________________________

Heart Disease____________________ Arthritis_________________________ Seizures_____________________________

Strokes_________________________ Kidney Disease___________________ Other ______________________________

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SOCIAL AND DRUG HISTORY: If your answer is **YES** please check ✓ all appropriate boxes

Are you sexually active? ☐ Have you traveled outside of Arizona? ☐ Do you drink alcohol? ☐

Do you smoke Tobacco? ☐ Do you take over the counter medication? ☐ Do you take street drugs? ☐

Do you have a Living Will? ☐ Are you taking any medications at this time? ☐ Allergic to any medication? ☐

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PAST MEDICAL HISTORY: If you ever had or presently have any of these problems please check ✓ all appropriate boxes

☐Glaucoma ☐High Cholesterol ☐GERD ☐Seizure/Epilepsy ☐Tuberculosis

☐Asthma ☐Heart Disease ☐Hepatitis ☐Anxiety ☐ HIV infection

☐COPD ☐Anemia ☐Arthritis ☐Depression ☐STD

☐Sleep Apnea ☐Diabetes ☐Fractures ☐Psychiatric Disorder ☐ Other_______

☐High Blood Pressure ☐Thyroid problems ☐Kidney Disease ☐Cancer _______________

GYNECOLOGICAL AND OBSTETRICAL HISTORY:

How many Pregnancies have you had? __________________ How many live births delivered? _________________

Number of Miscarriages________ Number of Elective abortions________ Number of Ectopic pregnancy__________

What age did you start your menstrual cycle? ____________________

Are you currently using a birth control method? __________If **YES**, what Method? _________________________________

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PAST SURGICAL HISTORY:

Have you ever been in the hospital? If **YES**, please give dates and what kind of surgical operations you have had? _____

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SYSTEM REVIEW: If you are having any of these problems, or recently had these problems, please write **when** and **how long** you have had them:

Breast Tenderness_________________ Headaches ________________________ Skin Rashes ____________________

Blurred Vision_____________________ Hemorrhoids______________________ Shortness of Breath______________

Chest Pain________________________ Hot Flashes_______________________ Urination Problems______________

Depression________________________ Leg Cramps_______________________ Vaginal Discharge________________

Dizziness_________________________ Nausea___________________________ Penile discharge _________________

Fainting Spells_____________________ Problems with sex organ____________ Other______________________________

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MR-40-06/10 Reviewed By ____ Date_______/_______/_______