

SYSTEMIC REVIEW:

Respiratory: Cont'd.

Asthma or Wheezing No Yes
 Difficult breathing No Yes
 Any trouble with lungs No Yes
 Pleurisy or Pneumonia No Yes

Cardiovascular:

Chest pain or angina pectoris No Yes
 Shortness of breath with walking or lying down. No Yes
 Difficulty walking two blocks No Yes
 Heart trouble or heart attacks No Yes
 High blood pressure No Yes
 Swelling of hands, feet or ankles No Yes
 Awakening in the night smothering No Yes
 Heart Murmur No Yes

Gastrointestinal:

Peptic Ulcer (stomach or duodenal) No Yes
 Vomiting blood or food No Yes
 Gallbladder disease No Yes
 Liver trouble No Yes
 Hepatitis No Yes
 Painful bowel movements No Yes
 Bleeding with bowel movements No Yes
 Black stools No Yes
 Hemorrhoids or piles No Yes
 Recent change in bowel habits No Yes
 Frequent diarrhea No Yes
 Heartburn or indigestion No Yes
 Cramping or pain in the abdomen No Yes
 Does food stick in throat No Yes

Genitourinary:

Loss of urine No Yes
 Frequent urination No Yes
 Night time urinating No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Kidney trouble No Yes
 Kidney stones No Yes
 Bright's disease No Yes

Gynecological:

Age period started _____
 How long do periods last _____ days

Gynecological: Cont'd.

Number of pregnancies _____
 Number of miscarriages _____
 Date of last cancer smear and results _____

Frequency of periods, every _____ days
 Any pain with your periods. _____ No Yes
 Number of children _____ Ages _____
 Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose veins No Yes
 Weakness of muscles or joints No Yes
 Any difficulty in walking No Yes
 Any pain in calves or buttocks on walking
 relieved by rest No Yes

Neuro-Psychiatric:

Have you ever had psychiatric care ? _____ No Yes
 Have you been advised to see a psychiatrist ? _____ No Yes
 Do you ever have, or have had, fainting spells ? _____ No Yes
 Convulsions No Yes
 Paralysis No Yes

Hematologic:

Are you slow to heal after cuts No Yes
 Blood disease No Yes
 Anemia No Yes
 Phlebitis No Yes
 Have you had difficulty with bleeding excessively
 after tooth extraction or surgery ? _____ No Yes
 Have you had abdominal bruising or bleeding? No yes

Allergic:

Any allergies, including medication No yes

Endocrine:

Thyroid disease No Yes
 Hormone therapy No Yes
 Any change in hat or glove size No Yes
 Any change in hair growth No Yes
 Have you become colder than before
 or skin become dryer No Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES:

1. Is there a history of skin reaction or other untoward reaction to sickness following injection or oral administration of:

Circle One

Penicillin or other antibiotics Yes No Don't Know
 Morphine, Codeine, Demerol or other narcotics Yes No Don't Know
 Novocain or other anesthetics Yes No Don't Know
 Aspirin, emperin or other pain remedies Yes No Don't Know
 Sulfa drugs Yes No Don't Know
 Tetanus antitoxin or other serums Yes No Don't Know
 Adhesive tape Yes No Don't Know
 Iodine or Merthiolate Yes No Don't Know
 Any other drug or medication Yes No Don't Know
 Any foods, such as egg, milk or chocolate Yes No Don't Know

What Drug or food?

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisones Yes No Don't Know
 ACTH Yes No Don't Know
 Anticoagulants Yes No Don't Know
 Tranquilizers Yes No Don't Know
 Hypotensives (high blood pressure medicines) Yes No Don't Know
 Has the patient ever recieved treatment for:
 Asthma, rheumatism or rheumatic fever ? Yes No Don't Know
 Aspirin Yes No Don't Know

Source of information if other than patient: _____

Signature of person acquiring this information: _____

 Doctor

 Date

 Signature of patient