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
- Vomitng 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 blooding 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	What Drug or food?
Penicillin or other antibiotics	Yes No Don't Know	
Morphine, Codeine, Demerol or other narcotics	Yes No Don't Know	
Novacain 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	_____
		_____
		_____
		_____
		_____

2. Drugs Recently Taken: Within the past six months has patent 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 _____