CASE HISTORY

LAST NAME: ______________________________ **FIRST NAME**: _________________________ **M.I.**: ___________

CHIEF COMPLAINT/REASON FOR VISIT:

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Review of Systems

Please mark the significant health history form below:

Constitutional	**Musculoskeletal**	**Cardiovascular**	**Blood / Lymphatic**
____None _ Developmental disability _ Weight Loss _ Fever _ Fatigue _ Trauma _ Other / medications	**___None** _ Fibromyalgia _ Muscular dystrophy _ Osteoarthirits _ Other / medications	**__ _None** _ Heart disease _ High Blood Pressure _ Stroke _ Vascular disease _ Other / medications	**___None** _ Anemia _ Leukemia _ Other / medications
Genitourinary **__None** _ Urinary tract infections _ Kidney ailments _ STD-herpes, Chlamydia, HIV _ Other / medications	**Ears, Nose, Mouth, & Throat** **___None** _ Upper respiratory tract infection _ Other / medications	**Integumentary (skin)**: **___None** _ Eczema _ Rosacea _ Psoriasis _ Other / medications	**Endocrine** **___None** _ Non-insulin depend. diabetes _ Insulin depend. Diabetes _ Thyroid dysfunction _ Hormonal dysfunction _ Other / medications
Neurological **___None** _ Multiple sclerosis _ Epilepsy _ Other / medications	**Respiratory** **___None** _ Asthma _ Bronchitis _ Emphysema _ Other / medications	**Psychiatric** **___None** _ Depression _ Schizophrenia _ Panic Disorder _ Other / medications	**Allergic / Immunologic** **___None** _ Drug allergy _ Environmental allergy _ Rheumatoid arthritis _ Lupus _ Other / medications
Gastrointestinal **___None** _ Crohn's disease _ Colitis _ Ulcer _ Digestive	**ADDITIONAL INFORMATION** ____________________ ____________________ ____________________ ____________________		

Social History

Do you use tobacco products? _ No _ Yes If yes, type / amount / how long: ______________________

Do you drink alcohol? _ No _ Yes If yes, type / amount / how long: ______________________

Do you use illegal drugs? _ No _ Yes If yes, type / amount / how long: ______________________

Have you ever been exposed to or infected with: _ Gonorrhea _ Syphilis _ HIV _ Hepatitis _ None

Doctors initials: