Adult History and Review of Systems Questionnaire

**Note:** This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_ Female \_\_ Spouse\Significant Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:** Your Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nationality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years \_\_\_\_\_\_\_\_\_\_\_\_\_

Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pets \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise (type/how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent/frequent travel destinations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use Yes \_\_ No \_\_ Type \_\_\_\_\_\_\_\_\_\_\_ Packs per day\_\_\_\_ for \_\_\_ years Quit \_\_\_\_\_\_\_  Alcohol Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drinks \_\_\_\_\_ per day \_\_\_ week\_\_\_ month \_\_\_ If heavy use, how many years \_\_\_\_\_Quit \_\_\_\_ Caffeine (coffee, tea, soda, chocolate) Servings per day \_\_\_\_\_\_

**Have YOU ever had? (IF YES, CHECK APPROPRIATE SPACES)**

\_\_Tuberculosis

\_\_Positive TB Skin Test

\_\_Arthritis  \_\_Gout

\_\_Frequent Bladder Infection

\_\_Kidney Disease  \_\_Polio

\_\_Chicken Pox

\_\_Anemia  \_\_Glaucoma

\_\_Frequent Sinus Infections

\_\_Hives  \_\_Depression

\_\_Head Injury

\_\_Blood transfusions  \_\_Sexually Transmitted

(Diseases: Herpes, HIV)

\_\_Heart Attack/Coronary  \_\_Artery Disease  \_\_Rheumatic Fever

\_\_High blood pressure

\_\_High cholesterol  \_\_Stroke

\_\_Gallstones  \_\_Liver Disease  \_\_Hepatitis/Jaundice

\_\_Heartburn / Reflux

\_\_Asthma  \_\_Seizures

\_\_Pneumonia  \_\_Pneumonia

\_\_Migraines \_\_Prostate Enlargement

\_\_Cystic Fibrosis

\_\_Cancer Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Heart failure

\_\_Diabetes

\_\_Ulcer disease

\_\_Emphysema

\_\_Emphysema

\_\_Osteoporosis

\_\_Kidney Stones

\_\_Infectious Mono

\_\_Thyroid Trouble

\_\_Broken Bones

\_\_Syphilis

\_\_Mumps

\_\_Malaria Other\_\_\_\_\_\_\_\_

\_\_Gonorrhea, Chlamydia

\_\_Intravenous drug abuse

\_\_Needle injury

**IMMUNIZATIONS:**

\_\_Measles, Mumps & \_\_Rubella Vaccine

\_\_Chicken Pox Vaccine

\_\_Hepatitis B Vaccine

\_\_Influenza Vaccine

\_\_Pneumococcal Vaccine

\_\_Tetanus booster

**PAST SURGICAL HISTORY:** If yes, please check the box and enter the year.

\_\_Eyes (Laser or Vision Corrected) \_\_Eyes (Cataract/Glaucoma) \_\_Ears Sinus/Nasal Septum  \_\_Tonsils/Adenoid \_\_Thyroid  \_\_Heart  \_\_Stomach \_\_Varicose Veins \_\_C-section \_\_Vasectomy  \_\_Tubal Ligation \_\_OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Gall Bladder  \_\_Appendix  \_\_Intestine/Colon  \_\_Hemorrhoids  \_\_Hernia  \_\_Breast  \_\_Uterus/Hysterectomy \_\_Ovaries  \_\_Spinal Surgery/Neck \_\_Prostate \_\_Spinal Surgery/Back  \_\_Orthopedic (Hips/ Knee \_\_Shoulder/ Feet/Hands)

**ALLERGIES**: and Bad Reactions to Medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** Name Dosage Times a day

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your FAMILY ever had? (**If yes check box and list RELATIONSHIP**)

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Crohn’s/colitis  \_\_Alzheimer’s  \_\_Alcoholism  \_\_Bleeding tendency \_\_Anemia \_\_Gout  \_\_Depression  \_\_Mental illness  \_\_Seizures  \_\_Migraine headaches

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Dialysis  \_\_Chronic lung disease \_\_Tuberculosis  \_\_Rheumatoid Arthritis \_\_Thyroid trouble  \_\_Osteoporosis  \_\_Cystic Fibrosis  \_\_Asthma  \_\_Peptic Ulcer  \_\_Gallstones

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

\_\_Cancer & Type  \_\_Diabetes  \_\_Cardiac \_\_Dysrhymthia  \_\_Congestive Heart Failure \_\_Coronary Artery Disease \_\_Valvular heart Disease \_\_High Blood Pressure \_\_High Cholesterol Stroke \_\_Kidney stones \_\_Kidney disease \_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYNECOLOGICAL/ OBSTETRICAL HISTORY:**

Name of OB-GYN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies? ­­­­ \_\_\_\_\_\_\_ Number of Births? \_\_\_\_\_\_\_ Vaginal / C-section (Please Circle) Method of Contraception \_\_\_\_\_\_\_

Age when you Started Menstruating? \_\_\_\_\_\_\_

Date of last Menstrual period? \_\_\_\_\_\_\_

Date of Last PAP?  \_\_\_\_\_\_\_

History of abnormal Pap’s  Yes/No (Please circle)

Date of Last Mammogram? \_\_\_\_\_\_\_

History of Abnormal Mammograms  Yes/No (Please circle) Menstrual Cycles Regular / Irregular (Please Circle) Pain with Periods  Yes / No (Please Circle) Age at Menopause \_\_\_\_\_\_\_

**Do you CURRENTLY have?** (IF YES, CHECK APPROPRIATE BOXES)

**NEUROLOGICAL**  \_\_Loss of Bowel Control \_\_Dizziness/Vertigo  \_\_Headaches  \_\_Numbness/Tingling  \_\_Passing Out  \_\_Seizures  \_\_Tremor **PSYCHIATRIC**  \_\_Anxiety  \_\_Change in Sleep Pattern \_\_Depression  \_\_Hallucinations  \_\_Suicidal Thoughts **ENDOCRINE**  \_\_Appetite Changes  \_\_Cold Intolerance  \_\_Increased Thirst  \_\_Increased Urination  \_\_Hair Changes  \_\_Sexual Dysfunction **HEMATOLOGY**  \_\_Easy Bruising  \_\_Enlarged Lymph Nodes \_\_Prolonged Bleeding

**GENERAL**  \_\_Fatigue  \_\_Fever  \_\_Weight Gain >10LBS \_\_Weight Loss >10LBS **SKIN**  \_\_Nail Changes  \_\_New Lesions  \_\_Rash  \_\_Skin Color Changes **HEENT**  \_\_Double Vision  \_\_Eye Pain \_\_Eye Redness \_\_Decreased Hearing \_\_Earache  \_\_Ear Ringing \_\_Nose Bleeds  \_\_Dry Mouth  \_\_Hoarseness  \_\_Oral Ulcers  \_\_Sore Throat  **NECK**  \_\_Neck Pain  \_\_Swollen Glands

**GENITOURINARY**  \_\_Vaginal Discharge  \_\_Menstrual Irregularities  \_\_Difficulty Starting/Stopping urinary Stream  \_\_Painful Urination  \_\_Change in Urinary Stream \_\_Increased Frequency  \_\_Blood in Urine  \_\_Loss of Bladder Control  \_\_Nighttime Urination  \_\_Urinary Retention  \_\_Urethral Discharge  \_\_Impotence  \_\_Penile Lesions  \_\_Testicular Mass  \_\_Testicular Pain **MUSCULOSKELETAL**  \_\_Decreased Range of Motion \_\_Joint Pain  \_\_Joint Redness  \_\_Joint Swelling  \_\_Joint Stiffness  \_\_Muscle Wasting  \_\_Muscle Weakness  \_\_Muscle Aches/Pains

**RESPIRATORY**  \_\_Chronic Cough  \_\_Decreased Exercise Tolerance \_\_Difficulty Breathing  \_\_Coughing Up Blood  \_\_Sputum Production  \_\_Wheezing  **BREAST** \_\_Breast Mass  \_\_Breast Pain  \_\_Nipple Discharge  \_\_Skin Changes **CARDIOVASCULAR**  \_\_Chest Pain  \_\_Leg Pains with walking  \_\_Leg Swelling  \_\_Night Awakening due to trouble \_\_Breathing  \_\_Palpitations  \_\_Shortness of Breath **GASTROINTESTINAL** \_\_Abdominal Pain  \_\_Change in Bowel Habits \_\_Constipation  \_\_Diarrhea  \_\_Nausea  \_\_Vomiting  \_\_Rectal Bleeding  \_\_Trouble Swallowing