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OUTPATIENT HISTORY

REVIEW OF SYSTEMS

MRN:

Name:

Age: Date of Birth:

N.03Z3

DATE:

REVIEW OF SYSTEMS: If you have any recent trouble with the following issues, check the problem(s) listed. If you do not have any of the problem selections, check the "No Problem" box.

GENERAL:

☐ Unusual weight changes	☐ Fatigue	☐ Pain
☐ Fever	☐ Weakness	☐ No Problem

SKIN:

☐ Rashes	☐ Changes in skin, hair or nails	
☐ Dryness		☐ No Problem

EYES:

☐ Pain	☐ Blurring vision	
☐ Excessive tearing	☐ Vision halos	
☐ Dryness	☐ Vision flashes	
☐ Redness	☐ Eyestrain	☐ No Problem

EARS:

☐ Drainage	☐ Constant ringing	
☐ Earache	☐ Hearing loss	☐ No Problem

NOSE:

☐ Nosebleeds	☐ Discharge	
☐ Post nasal drip	☐ Sinus pain	☐ No Problem

MOUTH:

☐ Gum soreness	☐ Tongue pain	
☐ Teeth condition		☐ No Problem

THROAT:	☐ Swelling	
☐ Hoarseness	☐ Trouble swallowing	☐ No Problem

LUNGS:

☐ Shortness of breath	☐ Wheezing	☐ Snoring
☐ Cough	☐ Phlegm/Sputum	☐ Apnea
☐ Coughing blood	☐ Pleurisy	
☐ Pneumonia	☐ Asthma	☐ No Problem

HEART & CIRCULATION:

☐ Chest pain, tightness or pressure	☐ Ankle swelling	
☐ Irregular heart beat	☐ Low blood pressure	
☐ Fast or slow heart beat	☐ High blood pressure	☐ No Problem

 PLEASE TURN PAGE TO COMPLETE

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OUTPATIENT HISTORY

REVIEW OF SYSTEMS (continued)

Patient Identification

URINARY:

- ☐ Frequency or painful urinating
- ☐ Urinating at night
- ☐ Pus in urine
- ☐ Blood in urine
- ☐ Losing control of urine/wetting self
- ☐ No Problem

STOMACH, INTESTINES AND COLON:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Food intolerance
- ☐ Vomiting blood
- ☐ Rectal bleeding
- ☐ Change in bowel habits
- ☐ Indigestion
- ☐ Constipation
- ☐ Flatus/Passing gas
- ☐ No Problem

MUSCLES, JOINTS & BONES:

- ☐ Joint stiffness or pain
- ☐ Joint swelling or redness
- ☐ Backache
- ☐ Muscle pains or cramps
- ☐ Limitation of joint or muscle movement
- ☐ Bone pain
- ☐ No Problem

NERVOUS SYSTEM:

- ☐ Fainting
- ☐ Blackouts
- ☐ Seizures/Epilepsy
- ☐ Paralysis
- ☐ Tremors
- ☐ Tingling of part of body
- ☐ Memory loss
- ☐ Headaches
- ☐ No Problem

HORMONES:

- ☐ Heat or cold intolerance
- ☐ Excessive thirst, hunger or urination
- ☐ No Problem

BLOOD/ALLERGIES:

- ☐ Anemia
- ☐ Easy bruising or bleeding
- ☐ Bleeding gums
- ☐ Hives or welts
- ☐ No Problem

PSYCHOLOGICAL:

- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Alcohol and drug abuse
- ☐ Loss of interest in activities that are normally enjoyed
- ☐ Difficulty concentrating
- ☐ Nervousness
- ☐ No Problem

GENITALS:

MEN Only:

- ☐ Sores
- ☐ Groin swelling
- ☐ Penile discharge
- ☐ Hernias
- ☐ Testicular pain or masses
- ☐ Breast lump
- ☐ Erection difficulties

WOMEN Only:

- ☐ Irregular periods
- ☐ Very painful periods
- ☐ Bleeding between periods
- ☐ Sores
- ☐ Vaginal discharge
- ☐ Breast lump
- ☐ Painful intercourse

☐ No Problem

DATE ______ PATIENT OR RESPONSIBLE PARTY SIGNATURE ______ DOCTOR'S SIGNATURE ______

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ADULT PATIENT HEALTH HISTORY

Age: ______ Sex: ______ Marital Status: ____________________

Education Level: ____________________

Home Phone: ____________________

Work / Cellular Phone: ____________________

Emergent Contact Person: ____________________

Emergent Phone Number: ____________________

Occupation: ____________________

Employer: ____________________

Prior Occupation: ____________________

MRN: **DOB:**

Name:

Address:

Phone:

Date:

Personal Physician:

PAST MEDICAL HISTORY

Please check any of the following conditions/problems/diseases that you either now have or have been diagnosed with in the past:

- ☐ Abuse - (Physical/Mental/Sexual/Verbal/etc.)
- ☐ Abnormal PAP
- ☐ Alcoholism / Drugs
- ☐ Anemia
- ☐ Anxiety / Nerves
- ☐ Arthritis
- ☐ Asthma
- ☐ Allergies
- ☐ Bleeding disease
- ☐ Blood tranfusion
- ☐ Blood Clots
- ☐ Cancer / Tumor
- ☐ Cholesterol (high)
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes / Sugar
- ☐ Epilepsy / Seizures
- ☐ Genetic diseases
- ☐ Glaucoma / Cataract
- ☐ Gout
- ☐ Headaches / Migraine
- ☐ Heart disease
- ☐ Hepatitis (Any)
- ☐ High Blood pressure
- ☐ Intestinal Disease
- ☐ Kidney or Bladder probs
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Serious accident / Injury
- ☐ Sexual diseases / VD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers / Stomach disease

Other: ____________________

____

____

Are you interested in learning more about your health condition? Yes_____ No_____

PAST SURGICAL HISTORY

List the year you had any of the following:

_______ Appendectomy
_______ Blood Transfusion
_______ Hysterectomy
_______ Gallbladder
_______ Heart / Cath
_______ Tubal / Vasectomy
_______ Hernia
_______ Tonsillectomy

Others: ____________________

____

HOSPITALIZATIONS / MAJOR TRAUMA

Date *(Start with most recent)*	**Reason**	*List any* **Major Tests or Procedures** *done*

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ADULT PATIENT HEALTH HISTORY

Patient Information

FAMILY HISTORY

Blood Relatives	Age if Living	Age at Death	Major Illnesses &/or Cause of Death *(Choose from PAST MEDICAL HISTORY section on previous page)*
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #: ____			
Sisters #: ____			
Children #: ____			

List any other diseases that your blood relatives have:

____

HABITS

Do you use (or have you used) any of the following:

Tobacco: ☐ Never ☐ Now ☐ Quit (year):________; Type Used: ☐ *cigarettes*, ☐ *cigars*, ☐ *pipe*, ☐ *smokeless*
Amount used per day:______________________ How many years: ___________

Alcohol: ☐ Never ☐ Social/Rare ☐ Now ☐ Quit (year):________; Type Used: ☐ *beer*, ☐ *wine*, ☐ *liquor*
Amount used per week:________ 12 oz beers; ________ 6 oz wine; ________ 2 oz shots

Drug Use: ☐ Never ☐ Now ☐ Quit (year):_______; Type: ☐ *pot*, ☐ *cocaine*, ☐ *IV*, ☐ *pain pills*, ☐ *other*:____________

Caffeine: # Per Day: ________ Coffee (cups); ________ Tea (glasses); ________ Soda (12 oz cans)

Exercise: ☐ None per week ☐ # of time/week = ________ Type:______________________

NUTRITIONAL ASSESSMENT

Do you follow a special diet or have any dietary restrictions? ☐ No ☐ Yes Specify______________________

HEALTH CARE MAINTENANCE

Immunization: Hep A: yr _______ Hep B: yr _______ Zostavax: yr _______ Pneumonia: yr _______ Tetnus: yr _______

Screening Exams: Cholesterol: yr ________ value ________ Mammogram: yr ________ PAP: yr ________
Colonoscopy: yr ________ PSA: yr ________ Dexa Scan: yr ________

COPING/STRESS TOLERANCE ASSESSMENT

Describe how you manage stress: ☐ Exercise ☐ Gardening ☐ Hobbies ☐ Read ☐ Sports ☐ TV
☐ Other: ______________________

Who lives with you? ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Other: ______________________

Current stressors: ☐ Family ☐ Friends ☐ Job ☐ Marriage ☐ Money ☐ Other: ______________________

In the past year have you had a major loss or change in your life? ☐ No ☐ Yes

VALUES/BELIEFS ASSESSMENT

Check if you have any of the following documents:
☐ Donor Card? ☐ Living Will? ☐ Durable Power of Attorney for Health Care?

Do you have religious or cultural practices we should be aware of? ☐ No ☐ Yes Specify______________________

Health care information can be shared with the following people: ______________________

____

Patient Signature / Date Completed

Physician Signature / Date Reviewed (optional)

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ADULT PATIENT HEALTH HISTORY
MEDICATION LIST

Patient Information

CURRENT MEDICATIONS *List all medications that you take routinely or that have been prescribed for you by a doctor* ***(include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)***

Medication	Dose	How Often	Reason

ALLERGIES ☐ None ☐ Antibiotics ☐ Foods ☐ Inhalants ☐ Insects

☐ Latex ☐ Meds ☐ Pollens ☐ Skin ☐ Transfusions ☐ X-Ray Contrast

Specify: ____

____

______________________________ ______________________________

Patient Signature / Date Completed **Physician Signature / Date Reviewed (optional)**

FOR OFFICE USE:	☐ Assistance required completing the form	☐ Non-English speaking patient

N.03YU