

<b>DATE:</b>		<b>REVIEW OF SYSTEMS</b>	
Name: _____		<b>HAVE YOU EVER HAD:</b>	NO YES DATE
Who is your Primary Care Physician: _____		Diabetes	
_____		Cancer	
Problem to be treated for today: _____		Anemia	
_____ <input type="checkbox"/> Right <input type="checkbox"/> Left		Gout	
Date of Injury: _____		Kidney/Bladder Trouble	
How Occurred: _____		High Blood Pressure	
_____		Heart Trouble	
Where Occurred: _____		Bleeding Disorder	
_____		Asthma/Hay Fever	
Name of Physician if previously treated for this problem: _____		Epilepsy/Seizures	
_____		Mental Retardation	
Hospitalized at: _____		Neurologic Disease	
_____		Stroke	
<b>IMPORTANT INFORMATION</b>		Blindness/Glaucoma	
In case of emergency contact: _____		Thyroid Problems	
_____		Deafness	
<b>DRUG ALLERGIES:</b> _____		Mental Illness	
_____		Ulcer/Stomach/Bowel Problems	
Medications you are taking: _____		Rheumatic Fever	
_____		TB/Valley Fever	
_____		Hepatitis	
_____		Pneumonia	
<b>PAST MEDICAL HISTORY</b>		Arthritis	
<b>PREVIOUS SURGERY:</b>	<b>DATE</b>	Phlebitis	
_____	_____	Are you now, or could you be possibly be pregnant?	
_____	_____	Prostate	
_____	_____	Emphysema	
_____	_____	AIDS	
_____	_____	Drug/Alcohol Addiction	
<b>RECENT HOSPITALIZATIONS:</b>		<b>MEDICAL INFORMATION</b>	
<b>DATE</b>	<b>DATE</b>	Are you a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	Do you consume alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	The above information is to the best of my knowledge a true statement of my current physical condition.	
_____	_____	Signed: _____	
_____	_____	Date: _____	