

**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  
 Vomiting 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 bleeding 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

Penicillin or other antibiotics ..... Yes No Don't Know  
 Morphine, Codeine, Demerol or other narcotics ..... Yes No Don't Know  
 Novocain 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

What Drug or food?

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

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