History and Review of Systems

REASON FOR VISIT	TODAY'S DATE	OCCUPATION

NAME OF PATIENT (Last, First, Middle)	DATE OF BIRTH

CIRCLE ANY OF THE FOLLOWING SYMPTOMS OR ILLNESSES YOU ARE CURRENTLY HAVING

FATIGUE	EARACHE	LOSS OF APPETITIE	DIZZINESS
FEVER	HEARING LOSS	TROUBLE SWALLOWING	FAINTING
MALAISE	RINGING IN EARS	NAUSEA/ VOMITTING	WEAKNESS / NUMBNESS
WEIGHT CHANGE	NOSE BLEEDS	ABDOMINAL PAIN	CONVULSIONS
HEADACHES	NASAL DISCHARGE	URINARY FREQUENCY	CONFUSION
FACIAL PAIN	THROAT PAIN	INCONTINENCE	MEMORY LOSS
SINUS PAIN	CHEST PAIN	KIDNEY STONES	ANXIETY
FLASHING LIGHTS	FAST HEART RATE	EXCESSIVE SWEATING	DEPRESSION
LIGHT SENSITIVITY	PALPITATIONS	EXCESSIVE THIRST	TROUBLE SLEEPING
EYE PAIN	SHORTNESS OF BREATH	CHANGE IN LIBIDO	DRINK ALCOHOL
BLURRY/DOUBLE VISION	COUGH	JOINT PAINS	SMOKE
NECK PAIN/STIFFNESS	WHEEZING	BACKACHE	DIABETES
RIGHT/ LEFT HANDED	ITCHING OR RASH	MUSCLE ACHES	HIGH BLOOD PRESSURE

PAST MEDICAL HISTORY/ ACCIDENTS	LIST OF MEDICATIONS

FAMILY MEDICAL HISTORY	ALLERGIES

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