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**REVIEW OF SYSTEMS AND
PAST MEDICAL HISTORY**

Date: _____ Age: _____ Height: _____ ft. _____ in. Weight: _____ lbs
Temperature: _____ °C Pulse: _____ Respiration: _____ Blood Pressure: _____
Service: _____ Otolaryngology _____

Please fill out the front and back of this page so that your doctor will have some background information about your medical condition.

I. Chief Complaint. *Concisely state the reason that you have come to see the doctor today.*

II. Review of Organ Systems. *If you have no symptoms in a certain area, please check the box marked "N". If you do have symptoms, please check the box marked "Y" and explain in the space provided.*

Y N

General symptoms (fever, weight loss, etc.): _____

Eyes: _____

Ears, nose, mouth and throat: _____

Heart: _____

Lungs: _____

Stomach and intestines (reflux, heartburn, blood in stools): _____

Bladder and urinary system: _____

Muscles and bones: _____

Skin and/or breasts: _____

Neurological (brain and nervous system): _____

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<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (nerves or anxiety, depression): _____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (thyroid, hormones, cholesterol): _____
<input type="checkbox"/>	<input type="checkbox"/>	Hematologic (bleeding disorders): _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic: _____

III. Past Medical History

Major Illnesses: High Blood Pressure Diabetes Heart Disease Other serious illnesses (Please list below)

Operations: _____

Drugs/Medicines that you are currently taking (include dose and frequency): _____

Drug Allergies: _____

IV. Family History. Please circle any of the following severe illnesses that may run in your family and list the family member involved (M=mother, F=father, S=sibling, GP=grandparent).

High Blood Pressure	M	F	S	GP	Cancer	M	F	S	GP
Heart Disease	M	F	S	GP	Bleeding Disorder	M	F	S	GP
Diabetes	M	F	S	GP	Anesthetic Complications	M	F	S	GP
Other: _____						M	F	S	GP

V. Social History

Occupation: _____

Tobacco use: packs per day _____ how many years? _____

Alcohol: type _____ amount per week _____

VI. Patient Signature _____ **Date** _____

VII. Physician Review

I have reviewed and confirmed the information noted above, and have annotated the records as needed.

 Date: _____ MD _____ MD

 Date: _____ MD _____ MD