Arne Wellness Center

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:______________NAME:________________________________DATE OF BIRTH__________
___MARRIED ___SINGLE ___DIVORCED ___WIDOWED; OCCUPATION:____________________
NO.OF CHILDREN:___TOBACCO USE: YES/NO HOW MUCH?_____/DAY HOW LONG? DATE QUIT____
ALCOHOL USE: HOW MUCH PER DAY?______CAFFEINE (COFFEE,TEA,COLAS) PER DAY___________

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY

- ☐ ☐ ALCOHOLISM
- ☐ ☐ ANEMIA
- ☐ ☐ ASTHMA
- ☐ ☐ CANCER/TUMOR
- ☐ ☐ DIABETES
- ☐ ☐ DRUG ABUSE
- ☐ ☐ DEPRESSION
- ☐ ☐ EPILEPSY/SEIZURES
- ☐ ☐ GLAUCOMA
- ☐ ☐ HEART DISEASE

YOU/YOUR FAMILY

- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ KIDNEY DISEASE
- ☐ ☐ LIVER DISEASE
- ☐ ☐ HEPATITIS
- ☐ ☐ LUNG DISEASE
- ☐ ☐ MENTAL ILLNESS
- ☐ ☐ OSTEOARTHRITIS
- ☐ ☐ OSTEOPOROSIS
- ☐ ☐ PHLEBITIS
- ☐ ☐ RHEUMATIC ARTHRITIS

YOU/YOUR FAMILY

- ☐ ☐ STROKE
- ☐ ☐ SUICIDE ATTEMPT
- ☐ ☐ THYROID DISEASE
- ☐ ☐ TUBERCULOSIS, TB
- ☐ ☐ ULCER IN GI TRACT
- ☐ ☐ VENEREAL DISEASE
- ☐ ☐ HIGH CHOLESTEROL
- ☐ ☐ HIV/IMMUNE DX
- ☐ ☐ OTHER___________

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

____
____
____
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REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:

Date Last Mammogram_________
Normal_____Abnormal_________
Date last PAP______________
Normal_____Abnormal_________
Age Onset Periods____________
Age Onset Menopause_________
Periods Regular? Yes_____No____
Number Pregnancies___________

SIGNATURE/REVIEWING PHYSICIAN____