HISTORY/REVIEW OF SYSTEMS:

Patient: _____ DOB:_____

Check if you have or ever have had any of the following:

☐ fevers lasting more than 2 weeks ☐ significant weight loss or gain ☐ night sweats

☐ head trauma ☐ sudden vision or hearing changes ☐ nose bleeds

☐ LUNG diseases ☐ COPD ☐ cough lasting more than 1 month ☐ asthma ☐ sleep apnea

☐ HEART diseases ☐ heart attack ☐ heart failure ☐ irregular heartbeat/atrial fibrillation

☐ VASCULAR diseases ☐ high blood pressure ☐ aneurysms

☐ STOMACH, BOWEL, or COLON diseases ☐ GI bleeding or ulcers

☐ KIDNEY diseases ☐ DIABETES ☐ LIVER diseases

☐ SKIN diseases ☐ rashes ☐ ulcers

☐ any CANCERS ☐ blood clotting or bleeding disorders

☐ NEUROLOGIC diseases ☐ stroke/ TIA ☐ migraine ☐ neuropathy ☐ fibromyalgia

☐ MUSCLE or JOINT diseases ☐ neck/back arthritis ☐ shoulder/arm/leg arthritis

☐ AUTOIMMUNE diseases ☐ rheumatoid arthritis ☐ Chron's/ulcerative colitis

☐ PSYCHIATRIC problems ☐ depression ☐ anxiety ☐ PTSD ☐ ADD

SURGERIES:

_____

_____

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