Patient Name:_____ **Date:**_____

REVIEW OF MEDICAL SYSTEMS

Patient Signature: _____

INSTRUCTIONS: Please circle any of the following conditions you presently have, or have had in the past.
This information is **VERY IMPORTANT** in evaluating your condition and determining your treatment.

MAJOR ILLNESSES:	Diabetes	Heart Disease	High Blood Pressure	Chest Pain	Cancer
	Murmur	Arrhythmia	Mitral Valve Prolapse	Infarct	Stroke
	CHF	Pacemaker	Other:_____		
RESPIRATORY:	Asthma	Bronchitis	Emphysema	Frequent Colds	COPD
	Infections	Smoker	Tuberculosis	Lung Disease	
	Breathing Problems		Shortness of Breath	Other:_____	
EENT:	Sinus Problems or Infections		Tonsillitis	Throat Infections	Glaucoma
	Ear Infections	Cataracts	Eye/Vision Problems	Headaches	Migraines
	Hearing Deficit		Other:_____		
GASTROINTESTINAL:	Ulcers	Reflux	Hiatal Hernia	Stomach Disorder	
	Bowel Disorder	Hemorrhoids	Irritable Bowel Syndrome	GI or Rectal Bleeding	
	Rectal Fissures	Other:_____			
Genito-Urinary:	Kidney Stones	Kidney Infections	Bladder Infections	Prostate Problems	STD
	Other:_____				
Vascular Disease or Blood Disorders:	Poor Circulation	PVD	Leg/Calf Pain	Night Cramps	Rest Pain
	Vein Problems	Swelling	Spider Veins	Varicose Veins	Phlebitis
	Leg Ulcers	Blood Clots	DVT	Pulm. Embolism	Bruising
	Bleeding/Clotting Problems		Anemia	Sickle Cell	Transfusions
Arthritis:	Rheumatoid	Osteo	Gout	Other:_____	
	Fibromyalgia	Lupus (SLE)	Auto-Immune Problems		
Skin Disorders:	Psoriasis	Skin Cancer	Other:_____		
Psychological:	Anxiety	Depression	Psychiatric Condition		
	Drug or Alcohol Dependency		Other:_____		
Misc. Conditions:	Epilepsy or Seizures		Thyroid Disease	Muscle Disease	HIV or AIDS
	Hepatitis	Pregnancy	Lyme Disease	Other:_____	