Main Line HealthCare
Physician Network

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Name_____Age_____Date of Birth_____
Primary Doctor_____ Date_____
Referring Doctor_____
Reason for Visit_____
_____
_____
_____
_____
Medications_____
_____
_____
_____
Past Medical History
Surgeries_____
_____
_____

Illnesses - Please check all that apply
High Blood Pressure ___ Diabetes ___ High Cholesterol___
Heart Disease ___ Stroke ___ Head Injury____
Neck Injury ____ Back Injury ___ Migraine____
Cancer ____ Epilepsy ____ Seizure___
Asthma ___ Lung Disease ___ Peptic Ulcer___
Psychiatric History____ Other_____
Allergies_____
_____
_____
Family History_____
_____
_____
Social History
Smoking_____Alcohol_____Occupation_____
Marital Status_____

REVIEW OF SYSTEMS (circle all that apply)

1. **Constitutional -** none fever chills weight loss

2. **Eyes -** none double vision blurring pain spots

3. **Ears, Nose, Throat -** none ear pain discharge hearing loss ringing
nose pain discharge loss of smell throat pain hoarse voice trouble swallowing

4. **Cardiovascular -** none chest pain heart attack irregular heart beat
coronary artery disease

5. **Respiratory -** none asthma COPD cough sputum pneumonia
tuberculosis

6. **Gastrointestinal -** none nausea diarrhea constipation vomiting
blood in stool hepatitis

7. **Genitourinary -** none bladder infections frequent urination kidney stones
bloody urine

8. **Musculoskeletal** none joint pain joint swelling stiffness muscle pain
weakness

9. **Skin -** none rash lesions itching birthmarks cancer

10.**Neurological -** none headache migraine head trauma stroke TIA
numbness tingling weakness

11.**Endocrine -** none thyroid abnormality diabetes hot flashes irregular menses

12.**Hematologic -** none easy bruising bleeding anemia

13.**Allergy/Immunology -** none sneezing runny nose itching HIV

14.**Psychiatric -** none anxiety depression bipolar

If you are not the patient, print your name_____
Relationship_____

Date Updated_____ Reviewed by_____