



Past Health History and Review of Systems

PATIENT NAME: _____ Date ____/____/____

Muscle:

Never Past Current

- Arthritis
- Degree of Disability
- Dislocations
- Fractures
- Sprains
- Kidney or UTI
- Muscle Weakness
- Tendonitis
- Night Cramps
- Trauma / Accidents
- Surgeries
- Swelling
- Wasting / Atrophy

Other: _____

Cardiovascular

Never Past Current

- Chest Pain
- Cold extremities
- Cough (severe)
- Heart disease
- Difficulty breathing
- Edema of the feet
- Hypertension
- Hypotension
- Inflammation of veins

Other: _____

Nerve

Never Past Current

- Equilibrium Disturbance
- Facial Weakness
- Hearing Disturbance
- Neck Loss of Motion
- Smell Disturbance
- Speech Difficulty
- Visual Disturbance
- Convulsions / Seizures
- Gait / In-coordination
- Motor Skill Loss
- Stroke / Coma / Paralysis
- Sensation Loss
- Loss of bladder Control
- Abnormal reaction to heat / cold
- Abnormal sweating
- Dizzy
- Head Aches
- Memory Loss
- Trauma to Head

Other: _____

Integument (Skin)

Never Past Current

- Fungal Infection
- Bruise easily
- Eczema
- Psoriasis

Other: _____

Hematologic / Lymphatic

Never Past Current

- Anemia
- Disease

Other: _____

Constitutional

Never Past Current

- Fatigue
- Fever

Other: _____

Nutritional Concerns?

List any medications currently on: _____

Dosage: _____

Reason for taking the medication: _____

1. _____
2. _____
3. _____
4. _____

Name of Medical Doctor: _____ Phone Number () - -

Write the amount you have of the following:

	Daily	Weekly	Monthly	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine (coffee / soda pop / tea / _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast foods / Greasy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Water: _____ glasses / day

Sleep: _____ hours / night
(on average)

Date: _____ Patient's Signature: _____