Review of Systems

Any unexplained fevers recently? yes ☐ no ☐ Any bowel/bladder problems? yes ☐ no ☐

Any kidney or urinary tract infection problems? Yes ☐ no ☐ Recent trauma or injury? Yes ☐ no ☐

Past History

Please record any surgeries/hospitalizations (including year performed)

____

____

____

____

Present Health Status

Do you presently have any of the following conditions:

High blood pressure ☐ Cholesterol ☐ Diabetes ☐ Heart disease ☐ Cancer ☐ Thyroid Disease ☐

Arthritis ☐ Asthma ☐ No prior significant illnesses ☐ Any other health conditions we should know about that are not listed above ☐

Past Injuries

None ☐ Motor vehicle accident with injuries ☐ Slip and fall ☐ Sports injury ☐ Work injury ☐

Dates of Trauma ____

Motor vehicle accident with NO injuries reported Date of trauma ____________________

Family History (Please record any significant illnesses)

Mother:Living ☐ Deceased ☐ ____________________ Father:Living ☐ Deceased ☐ ____________________

Sibling(s):Living ☐ Deceased ☐ ____

Grandmother:Living ☐ Deceased ☐ ____

Grandfather:Living ☐ Deceased ☐ ____

Social History

Occupation ____________________

Does your work involve: heavy lifting ☐ prolonged sitting ☐ repetitive motion ☐ travel ☐

Tobacco Usage

None ☐ Cigarettes (packs per day ______)

Alcohol Usage

None ☐ Rarely ☐ Social drinker ☐ Recovering alcoholic ☐

Exercise: None ☐ Occasional ☐ Regular ☐ Frequent ☐ What ______________________________