



**Family Medical History:**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sisters: \_\_\_\_\_

Brothers: \_\_\_\_\_

Children: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**Review of Systems: Check any that apply**

**Head/Neck:**    Blurred vision    Ear aches    Nosebleeds    Enlarged Lymph Node

**Throat:**    Sore Throat    Ulcers    Loose teeth

**Chest:**    Cough    Sputum    Wheezing    Short of breath

**Heart:**    Chest Pain    Irregular heartbeat

**Back:**    Sore Back    Shoulder pain

**Abdomen:**    Bloating    Nausea    Diarrhea    Constipation

**Rectal:**    Bloody stools    Pain with BM

**Extremities:**    Leg pain with walking    Ulcers    Varicose veins

**Neuro:**    Headache    Seizures    Weakness    Paralysis

**Skin:**    Rashes    Abscess    Cysts    Enlarging moles

**Urinary:**    Bloody urine    Painful urination

**Other:**    Fever    Chills    Vomiting    Night sweats

**This health information sheet is accurate to the best of my knowledge.**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_