Maineville Family Physician

History and Review of Systems

Name:_____ DOB_____

History of Medical Problems: Please circle the conditions which you have been diagnosed with by a physician and the year or age you were when diagnosed.

Condition/Year or age at diagnosis

ADHD, with or without hyperactivity (please circle which one)
Alcoholism
Allergic rhinitis
Alzheimer's disease
Anemia
Asthma
Cancer, what type?
Carotid Stenosis (narrowing of the arteries in the neck)
Cataracts
Cerebrovascular Accident (stroke)
Cervical disc disease (herniated discs in neck)
Congestive Heart Failure (CHF)
COPD (emphysema)
Colonic polyps (ployps in the colon)
Coronary artery disease (clogged heart arteries)
Myocardial infarction (MI or heart attack)
Crohn's disease
Deep Venous Thrombosis (DVT) (blood clot in leg requiring Coumadin)
Dementia
Diabetes mellitus, type 2 (adult onset)
Diabetes mellitus, type 1 (child onset)
Eczema
Fibromyalgia
GERD/hiatal hernia/PUD (ulcers)
Glaucoma
Gout
Hemorrhoids
Hyperlipidemia (high cholesterol)
Hypertension (high blood pressure)
Hypothyroidism (low thyroid function)
Irritable Bowel Syndrome (IBS)
Kidney disease
Kidney Stones
Liver disease
Lumbar Disc Disease (herniated discs in low back)
Lumbar Spinal Stenosis (narrowing of spinal canal in low back)

Name:_____ DOB_____

Condition/Year or age at diagnosis

Lupus (SLE)
Macular Degeneration
Migraine headache
Obesity
Osteoarthritis (arthritis form overuse or aging)
Osteoporosis
Parkinson's Disease
Peripheral artery disease (arterial blockage in legs or aorta)
Pulmonary Embolism (blood clot to the lung)
Psoriasis
Rheumatoid arthritis
Seizure disorder (epilepsy)
Sleep apnea
Subarachnoid hemorrhage (bleeding brain aneurysm)
TMJ syndrome
Ulcerative Colitis
Venous Stasis (swelling in legs due to poorly functioning veins)

Mental Illness
Condition/Year or age at diagnosis
Bipolar disorder (manic depressive disorder)
Depression
Suicide attempt(s)
Generalized Anxiety disorder
Mental retardation/ Developmental Delay
Obsessive Compulsive Disorder (OCD)
Panic Disorder
Post-traumatic stress disorder (PTSD)
Schizophrenia
Other mental illness

Conditions for Men Only
Condition/Year or age at diagnosis

Benign Prostatic Hypertrophy (BPH)
Elevated PSA
Erectile dysfunction (ED or impotence)
Genital Herpes
Prostatitis
Other

Name:_____ DOB_____

Conditions for Women Only
Condition/Year or age at diagnosis

Benign breast lump
Cervical Dysplasia
Dysmenorrhea (abnormally painful periods)
Endometriosis
Fibrocytic breast change
Genital herpes
Premenstrual Dysphoria Disorder (PMDD)
Other

Surgical History

Please circle the surgeries you have had and write the year completed or your age when surgery was performed.

Never had any surgery (Skip to Family History)

Orthopedic Surgery Age or time of surgery

Arthroscopic surgery (scope of the knee? Shoulder? Elbow? Which side Right, Left, or Both?
Bunionectomy (removal of bunions) Right? Left? Or Both?
Carpal Tunnel release? Right? Left? Or Both?
Ganglion Cyst surgery? Right, Left, or Both
ORIF (open reduction and internal fixation-plates, screws or pins for broken bones) which bone? Right, Left or both
Spine surgery of neck? Low Back?
Total Joint Replacement of Knee? Hip? Right? Left? Both?
Other orthopedic surgery not mentioned?

Surgery for Women Only/ Year or age at diagnosis

Breast biopsy Benign (no cancer)? Right or left or both?
Brest augmentation or reduction
Bilateral Tubal Ligation: (tubes tied)
C-Section for what reason?
D&C (cleaning out uterus) why?
Endometrial ablation? (Burning out the lining of the uterus to stop periods)
Laparoscopic surgery why?
LEEP surgery (partial removal of cervix for abnormal PAP smears)
Total Abdominal Hysterectomy with or without removal of right or left or both ovaries? Why? Any Cancer?
Vaginal Hysterectomy with or without removal of
Other female surgery?

Name:_____ DOB_____

Surgery for Men Only/ Year or age at diagnosis

Breast biopsy
Prostatectomy (removal of prostate)
Prostate biopsies?
TURP (remaining procedure of enlarged prostate)
Testicular surgery
Vasectomy
Other male surgery

General Surgeries/Year or age at diagnosis

Appendectomy (appendix out)
Angioplasty with/ without coronary artery stent?
CABG (cardiac bypass surgery) If so, how many vessels were bypassed?
Cancer Surgery
Carotid Endarterectomy (removing plaque buildup in carotid arteries due to blockage)
Cataract Surgery, Right, Left, or Both?
Cholecystectomy (gallbladder removed) laparoscopic or open?
Gastric bypass, which kind?
Hemorrhoidectomy
Hernia repair, right or left or both sides? Inguinal or ventral or umbilical?
Surgical procedures to pen up blocked blood vessels in the arteries? Which kind?
Ear tubes?
Sinus surgery to pen up sinuses? Deviated septum?
Tonsillectomy
Adenoidectomy
Thyroidectomy
Wisdom teeth extraction under general anesthesia (put totally asleep)
Other surgery not mentioned?

Non-Surgical Testing Procedures/ Year or age procedure was completed

Cardiac Catheterization (angiogram)
Cardiac stress test
Colonoscopy
Dexascan (bone density scan)
EGD (stomach scope)
MRI of brain? Neck? Low back? Other?

Occupational Injuries
BWC cases? Date of Injury? Is the Case Open?

Name:_____ DOB_____

Allergies please list below

Medications please list below

Family History

Please complete your family's medical history. Please write in any significant medical conditons for each family member. Conditions could include cancer (indicate which kind), heart attack or heart disease, high cholesterol, high blood pressure (HTN), diabetes, adult onset vs child, COPD (emphysema), etc

If your family member is deceased, please circle that option and indicate at what age they died and what medical condition they died of.

Mother: Conditions? If deceased what age and condition?

Father: Conditions? If deceased what age and condition?

Maternal Grandmother: Conditions? If deceased what age and condition?

Paternal Grandmother: Conditions? If deceased what age and condition?

Maternal Grandfather: Conditions? If deceased what age and condition?

Paternal Grandfather: Conditions? If deceased what age and condition?

Name:_____ DOB_____

Family History Continued

Brothers: Conditions? if deceased, at what age?

Sisters: Conditions? If deceased, at what age?

Sons: Conditions? If deceased, at what age?

Daughters: Conditions? If deceased at what ager?

Other?

Social History

Do you smoke? Yes No Use to

Years Smoking?

Packs per day?

When did you quit?

Symptoms of nicotine addictions? Yes or No

Desire to quit? Yes or No

Do you drink alcoholic beverages?

Never

Occasional (1-2 drinks per day or less)

Moderate (>14 drinks per week)

Heavy (> 6 drinks per day)

Do you use illicit drugs? No/ marijuana/cocaine/hallucinogens/narcotics

Occupation? Student/homemaker/retired/employed part-time/employed full time/ unemployed

If applicable What kind of work do you do?

Where do you work?

Name:_____ DOB_____

Social History Continued

Marital Status:

Single

Married

Engaged

Widowed

Divorced

Involved in an opposite sex relationship/ Involved in same sex relationship.

Children: None or Names and month/ year born

Who do you live with?

I live alone

Spouse

Children

Siblings

Parents

Father

Mother

Significant Others