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# MEDICAL HISTORY-REVIEW OF SYMPTOMS

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PATIENT NAME: DATE:

MEDICAL HISTORY / REVIEW OF SYMPTOMS

| Please check if you have had a history of any of the following | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| GENERAL | | | CARDIOVASCULAR | | |
| Are you currently pregnant? | | | Chest pain, Angina | | |
| Diabetes | | | Heart Attach Myocardial Infection | | |
| Stroke | | | Palpitations | | |
| Kidney Disease | | | High Blood Pressure, Hypertension | | |
| Ulcers | | | Shortness of Breath | | |
| Asthma or Lung Disease | | | Ankle Swelling | | |
| Cancer TYPE: | | | HEMATOLOGIC | | |
| Fatigue | | | Anemia | | |
| Weakness | | | Blood clots | | |
| Fevers | | | Bleeding tendency | | |
| Skin Problems / Disorders TYPE: | | | Easily bruised | | |
| Rheumatic Fever | | | Circulatory problems | | |
| Tuberculosis | | | Blood thinners (currently on?) | | |
| Recent weight loss / gain. How much? | | | (If yes, type?) | | |
| BLOOD BORNE PATHOGENS | | | Phlebitis | | |
| HIV / AIDS | | | MUSCULOSKELETAL | | |
| Hepatitis | | | Joint Pain | | |
| Other | | | Joint Swelling | | |
| SITES OF INJECTION | | | Muscle weakness | | |
| Urinary | | | Muscle tenderness | | |
| Dental | | | Morning stiffness | | |
| Other | | | Arthritis / Osteoarthritis | | |
| NEUROLOGICAL | | | Rheumatoid Arthritis | | |
| Headaches | | | Bunions | | |
| Dizziness | | | Osteoporosis | | |
| Fainting | | | Previous bone density test? | | |
| Memory Loss | | | Bone / Joint Infections | | |
| Loss of consciousness | | | Gout | | |
| Muscle Spasms | | | PSYCHOLOGICAL | | |
| Numbness or tingling of hands / feet | | | Depression | | |
| Blindness or trouble seeing | | | Anxiety disorder | | |
| Deafness or trouble hearing | | | Other | | |
| Seizures | | | | | |

Other illness or diseases which are not listed? Please describe:

FAMILY HISTORY - Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Diabetes (sugar) | | | Abnormal bleeding tendencies | | |
| Heart Disease | | | Rheumatoid Arthritis | | |
| Anesthetic complications | | | Osteoarthritis | | |
| Cancer TYPE: | | | Gout | | |

SOCIAL HISTORY

What is your approximate weight? Lbs. Height? Ft. In.

Occupation: No. of years: Job duties:

Do you smoke? (circle one) Yes No Past If yes or past, how many packs per day? How many years?

Are you (circle one) right handed left handed

What is your principle support system? (example: spouse, family, friends, church)

I, as the patient, state the information is correct and accurate to the best of my knowledge.

I have reviewed this information with this patient.

Patient / Guardian signature

Tarek Bittar, M.D.