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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.		