[ ] Hageman Chiropractic Health Center- Campus Clinic – 320 Porter Ave. Buffalo, NY 14201
[ ] D'Youville Chiropractic Clinic at ECMC – 462 Grider Street Buffalo, NY 14215

# Review of Systems and Patient Medical History

Printed Patient Name: _____ Date_____

Printed Parent/Legal Guardian Name: _____ Relationship:_____

**Please check appropriate response if the patient currently has or has had in the past any problems related to the following systems. Complete all other questions with up to date and appropriate answers.**

**General History**
1. ☐ Height or weight change
2. ☐ Fever/chills/night sweats
3. ☐ Anemia/bleeding/bruising
4. ☐ Malaise/fatigue/weakness
5. ☐ Cancer diagnoses

**Cardiovascular System**
6. ☐ Shortness of breath/chest pain
7. ☐ High blood pressure/heart disease

**Respiratory System**
8. ☐ Difficulty in breathing
9. ☐ Coughing/wheezing/asthma
10. ☐ Lung Infection/disease
11. ☐ Cigarette/cigar/pipe/chew
12. ☐ Never smoked
13. ☐ Current use of chew
14. ☐ Former smoker
15. ☐ Current smoker
16. ☐ Started in ___ (year)
17. ☐ Quit in _____(year)
    # _____ packs per
    ☐ day or ☐ week

**Skin/Hair/Nails**
18. ☐ Change in skin/rashes/itching
19. ☐ Skin growths/lesions/cancer
20. ☐ Change in hair quality/growth
21. ☐ Change in nails (finger/toe)

**Endocrine System**
22. ☐ Heat/cold intolerance/diabetes
23. ☐ Thyroid Problems/irradiation
24. ☐ Blurred/double vision
25. ☐ Ringing in ears/ear symptoms
26. ☐ Nose or sinus symptoms

**Abdomen**
27. ☐ Abdomen pain
28. ☐ Abdominal swelling or distension
29. ☐ Jaundice
30. ☐ Abdominal aortic aneurysm
31. ☐ Appendicitis

**Gastrointestinal System**
32. ☐ Change in appetite/food tolerance
33. ☐ Nausea/vomiting/vomit blood
34. ☐ Indigestion/heartburn/ulcer
35. ☐ Stomach or abdomen symptoms
36. ☐ Change in stool/color/etc.

**Urinary System**
37. ☐ Frequent/painful/night urination
38. ☐ Difficulty starting/holding urine
39. ☐ Flank/kidney/pelvic pain
40. ☐ Urinary tract infections

**Breast**
41. ☐ Bumps/lumps/dimples
42. ☐ Pain/tenderness/discharge
43. ☐ Change in color/size/shape

**Reproductive System**
44. ☐ Genital infection/sores/pain
45. ☐ Sexually transmitted infection

**Female Patients**
46. ☐ 1st period _____age:_____
47. ☐ PMS symptoms
48. ☐ First date of last cycle_____
49. ☐ Non-period bleeding/spotting
50. ☐ Date of last Pap smear_____
51. ☐ Date of last Mammogram ____

**Neurologic System**
52. ☐ Headaches/dizziness
53. ☐ Seizures/ticks/spasm/tremor
54. ☐ Weakness/numbness/tingling

**Psychological History**
55. ☐ Anxiety/nervousness/stress
56. ☐ Psychologic diagnoses
57. ☐ Depression

**Musculoskeletal System**
58. ☐ Joint pain/swelling
59. ☐ Muscle cramps/weakness/wasting
60. ☐ Neck pain/back pain
61. ☐ Arm pain/leg pain
62. ☐ Fractures/dislocations/sprains
63. ☐ Arthritis/ Auto-immune disorder
64. ☐ Other accident/injury/disability

**Surgical/Hospitalization History (Please List What Type, When and Where)**

Spinal Surgery ☐ No ☐ Yes| Year _____Facility _____
Neck Surgery ☐ No ☐ Yes| Year _____Facility _____
List All Surgeries
1. _____ Year ____ Facility _____
2. _____Year ____Facility _____

**Allergies to Medications** ☐ Yes ☐ No known allergies

1. Medication: _____ Reaction: _____
2. Medication: _____ Reaction: _____
3. Medication: _____ Reaction: _____
4. Medication: _____ Reaction: _____
5. Medication: _____ Reaction: _____

**Allergies to Food, Other Factors, Supplements and/or Herbs.** ☐ **None** ☐ **Yes, If Yes, please check any listed below that applies:**

| | | | |
|---|---|---|---|
| ☐ Eggs | ☐ Wheat | ☐ Tree Nuts | ☐ Latex |
| ☐ Banana | ☐ Soy | ☐ Dander | ☐ Insects Stings |
| ☐ Gluten | ☐ Peanuts | ☐ Pollen | ☐ Mold |
| ☐ Shellfish | ☐ Milk | ☐ Pets | ☐ Other_____ |

**List medication(s), vitamins, supplements, the purpose and the dosage you are currently taking.**

*If you have a list of your medications, please give it to the office staff to make copy for your medical records.*

**A. Prescription Medications** **The Purpose and the Dosage of the medication.**

1. _____ _____
2. _____ _____
3. _____ _____

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**B. Non-prescription medications The purpose and dosage:** _____

**C. Vitamin or Supplement Use** _____

**Date of most recent screenings**

1. ☐ Physical Exam Year _____
2. ☐ Blood/Urine Test Year _____
3. ☐ Mammogram Year _____
4. ☐ Colonoscopy Year _____
5. ☐ Prostate Year _____
6. ☐ Cardiac Stress test Year _____
7. ☐ Bone Density Year _____
8. ☐ Ultrasound Year _____
9. ☐ Imaging ☐ X-ray Year ____ ☐ MRI Year ____ ☐ CT Year ____
10. ☐ Other – Specify: _____

**History of Trauma**

1. ☐ Yes ☐ NO | Car Accident , Year _____Injured area _____
2. ☐ Yes ☐ NO | Work Injury , Year _____Injured area _____
3. ☐ Yes ☐ NO | Broken Bones, Year _____Injured area _____
4. ☐ Yes ☐ NO | Sport Injury , Year _____Injured area _____
5. ☐ Yes ☐ NO | Head Trauma, Year _____Injured area _____
6. ☐ Yes ☐ NO | Major Fall , Year _____Injured area _____

**Social History / Health Habits**

Do you drink Energy Drinks? ☐ Yes ☐ No ☐ Caffeinated ☐ Decaf How much per day? _____ Cup(s) ☐ Regular ☐ Diet

Do you drink Soda? ☐ Yes ☐ No ☐ Caffeinated ☐ Decaf How much per day? _____ Cup(s) ☐ Regular ☐ Diet

Do you drink Coffee? ☐ Yes ☐ No ☐ Caffeinated ☐ Decaf How much per day? _____ Cup(s)

Do you drink Water? ☐ Yes ☐ No | How much?_____oz How much per day? _____ Glass(es)

Do you drink Alcohol? ☐ Yes ☐ No | How much?_____How often? _____

Recreational Drug Use ☐ Yes ☐ No | How often? _____

Do you Exercise? ☐ Yes ☐ No | What type/how long / how often? _____

**FAMILY HISTORY** Fill in health information about your family (father, mother, siblings, and grandparents).

**Adopted? ☐ Yes**

| Relation | Age | State of Health | Age of Death | Cause of Death | | X if, your blood relatives had any of the following Disease | | Relationship |
|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | Arthritis, rheumatoid arthritis | |
| Mother | | | | | | | Cancer (type) | |
| Brother(s) | | | | | | | Diabetes | |
| | | | | | | | Heart Disease, Strokes | |
| | | | | | | | High Blood Pressure | |
| Sister(s) | | | | | | | Kidney Disease | |
| | | | | | | | High cholesterol | |
| | | | | | | | Arthritis, rheumatoid arthritis | |
| Maternal Grandfather | | | | | | | Multiple Sclerosis | |
| Maternal Grandmother | | | | | | | Depression | |
| Paternal Grandfather | | | | | | | Autoimmune Disorders | |
| Paternal Grandmother | | | | | | | Psychologic diagnoses | |

***I do hereby attest that all information completed on this form is true, accurate and completed to the best of my knowledge.***

Patient Signature_____Date_____

Parent / Legal Guardian _____ Date _____

Intern Signature _____ Date_____

Clinician Signature _____ Date _____