PERSONAL MEDICAL HISTORY
REVIEW OF SYSTEMS

Please check if any of the following applies to you, and list any medication for each condition. If you have none of these conditions, then please check none.

Allergies (please list) ☐ **None** Medication Allergies: Environmental Allergies:	**Genitourinary:** ☐ **None** ☐ Kidney Stones ☐ Prostate Cancer ☐ STDs: ☐Uterine Cancer ☐Urinary Infections ☐ Other:	**Musculoskeletal:** ☐ **None** ☐ Ankylosing Spondylitis ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Scoliosis ☐ Other:
Cardiovascular: ☐ **None** ☐ Arrhythmia ☐ High Cholesterol ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Other:	**Head/ENT:** ☐ **None** ☐ Dry Mouth ☐ Sinusitis ☐ Hearing Loss ☐ Ears Ringing ☐ Other:	**Neurological:** ☐ **None** ☐ Bell's Palsy ☐ Brain Tumor ☐ Migraines ☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Other:
Constitutional: ☐ **None** ☐ Dizziness ☐ Fever ☐ Nausea ☐ Other:	**Hematological:** ☐ **None** ☐ Anemia ☐ Breast Cancer ☐ Leukemia ☐ Sickle Cell Disease ☐ Other:	**Psychiatric:** ☐ **None** ☐ Attention Disorder ☐ Anxiety Disorder ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Other:
Endocrine: ☐ **None** ☐ Crohn's Disease ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Thyroid Disorder ☐ Other:	**Immunological:** ☐ **None** ☐ HIV ☐ Sarcoidosis ☐ Sjogren's Syndrome ☐ Lupus ☐ Other:	**Respiratory:** ☐ **None** ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Lung Cancer ☐ Other:
Gastrointestinal: ☐ **None** ☐ Colon Cancer ☐ Colitis ☐ Gallstones ☐ Hepatitis ☐ Gastroesophageal Reflux ☐ Other:	**Integumentary (Skin):** ☐ **None** ☐ Acne Rosacea ☐ Psoriasis ☐ Eczema ☐ Skin Cancer ☐ Other:	**Alcohol Use: Y N** **Tobacco Use: Y N** **Recreational Drug Use: Y N**

Please list all current medications including non-prescription and birth control.