# Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctor, it is important for me to know this information so I can provide you with the best health care possible.

Name_____ Date_____
Date of Birth _____ ☐Male ☐ Female

SOCIAL HISTORY:
Tobacco Use: ☐ No ☐ Yes Packs per day: _____
Alcohol Use _____ Drinks _____ per ☐day ☐ week ☐ month
Exercise (type/how often?)_____
Caffeine (coffee, tea, soda, chocolate) Servings per day: _____

**Do you CURRENTLY have? (if yes, check appropriate boxes)**

**GENERAL:**
☐Fatigue
☐Fever
☐Weight Gain >10 pounds
☐Weight Loss >10 pounds

**RESPIRATORY:**
☐Chronic Cough
☐Decreased Exercise Tolerance
☐Difficulty Breathing
☐Coughing Up Blood
☐Sputum Production
☐Wheezing

**HEENT**
☐Double Vision
☐Eye Pain
☐Eye Redness
☐Decreased Hearing
☐Earache
☐Ear Ringing
☐Nose Bleeds
☐Dry Mouth
☐Hoarseness
☐Oral Ulcers
☐Sore Throat

**HEMATOLOGY**
☐Easy Bruising
☐Enlarged Lymph Nodes
☐Prolonged Bleeding

**NEUROLOGICAL**
☐Loss of Bowel Control
☐Dizziness/Vertigo
☐Headaches
☐Numbness/Tingling
☐Passing Out
☐Seizures
☐Tremor

**CARDIOVASCULAR**
☐Chest Pain
☐Leg Pains with walking
☐Leg Swelling
☐Night awakening due to trouble breathing
☐Palpitations
☐Shortness of Breath

**SKIN**
☐Nail Changes
☐New Lesions
☐Rash
☐Skin Color Changes

**MUSCULOSKELETAL**
☐Decreased Range of Motion
☐Joint Pain
☐Joint Redness
☐Joint Swelling
☐Joint Stiffness
☐Muscle Wasting
☐Muscle Weakness
☐Muscle Aches/Pains

**GASTROINTESTINAL**
☐Abdominal Pain
☐Change in Bowel Habits
☐Constipation
☐Diarrhea
☐Nausea
☐Vomiting
☐Rectal Bleeding
☐Trouble Swallowing

**ENDOCRINE**
☐Appetite Changes
☐Cold Intolerance
☐Increased Thirst
☐Increased Urination
☐Hair Changes
☐Sexual Dysfunction

**GENITOURINARY**
☐Vaginal Discharge
☐Menstrual Irregularities
☐Difficulty Starting/Stopping urinary
☐Painful Urination
☐Change in Urinary Stream
☐Blood in Urine
☐Loss of Bladder Control
☐Nighttime Urination
☐Urinary Retention
☐Urethral Discharge
☐Impotence
☐Penile Lesions
☐Testicular Mass
☐Testicular Pain

**NECK**
☐Neck Pain
☐Swollen

**PSYCHIATRIC**
☐Anxiety
☐Change in Sleep Pattern
☐Depression
☐Hallucinations
☐Suicidal Thoughts