MOUNTAINSTAR

Ogden Specialty Clinic

affiliated with Ogden Regional Medical Center

PAST MEDICAL HISTORY - (check the items that apply and then write in the date of occurrence)

Have you been treated in the past and/or now for the following?

Y	N		Y	N		Y	N	
☐	☐	Glaucoma _____	☐	☐	Heart attack _____	☐	☐	Acid reflux (GERD) _____
☐	☐	Anemia _____	☐	☐	High blood pressure_____	☐	☐	Gout _____
☐	☐	Hepatitis _____	☐	☐	Pneumonia _____	☐	☐	Cancer _____
☐	☐	Diabetes _____	☐	☐	Asthma _____	☐	☐	Arthritis _____
☐	☐	Stroke _____	☐	☐	Bronchitis _____	☐	☐	Depression _____
☐	☐	Seizure _____	☐	☐	Emphysema _____	☐	☐	Anxiety _____
☐	☐	Heart failure _____	☐	☐	Tuberculosis _____	☐	☐	Kidney Stones _____
☐	☐	Heart murmur _____	☐	☐	Stomach ulcers _____	☐	☐	Other _____

Have you ever had surgery? (Procedure / Date)

_____ _____

_____ _____

_____ _____

Have you ever had a serious reaction to an anesthetic agent? (e.g. hyperthermia?) ☐ Yes ☐ No

Review of Systems

Do you now or have you had any problems related to the following systems?
Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Recent weight gain or loss	Y	N

Eyes

Blurred vision	Y	N
Double vision	Y	N

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck	Y	N

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Pain Y N

Other _____

Allergic/Immunologic

Hay fever Y N
Drug allergies Y N
Other _____

Neurological

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular

Chest pain Y N

Varicose veins Y N
High blood pressure Y N
Other _____

pain
Back
pain Y N
Other
_____

Ear/Nose/Throat/Mouth

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Hearing problems Y N

Genitourinary

Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other
_____

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Exposure to TB Y N
Snoring Y N

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other
_____

Psychologic

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you ever considered suicide? Y N
Other
_____

OVER →

Do you smoke? ☐ Yes ☐ No How many years? _____

Have you quit smoking? ☐ Yes ☐ No When? _____

How many alcoholic beverages do you consume each week? _____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

FAMILY HISTORY

Y	N	Bleeding disorders
Y	N	Serious reaction to anesthetic agent, e.g hyperthermia
Y	N	Heart disease
Y	N	High Blood Pressure
Y	N	Cancer
Y	N	Diabetes