**Detailed History and Review of Systems**

**Date of Service**: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Self-Reported History:**

Please indicate if you have or have not ever had the following conditions:

**Head**

Yes No

skull injury

facial injury

head surgery

other head condition

**Neck**

Yes No

thoracic outlet syndrome

congenital cyst

neck surgery

other neck condition

**Eyes and Vision**

Yes No

corrective lenses

color perception defect

monocular vision

retinal detachment

progressive retinopathy

optic neuritis

eye surgery

peripheral vision defect

amblyopia (lazy eye)

other eye or vision

condition

**Ears and Hearing**

Yes No

vertigo (dizziness)

impaired balance

decreased hearing

ear canal condition

external ear condition

ear tumor

recurrent ear infections

Ménière’s disease

ear or ear canal surgery

other ear or hearing

condition

**Dental**

Yes No

jaw condition

orthodontic appliance

other dental condition

**Nose or Throat**

Yes No

throat surgery

voice condition

nose surgery

allergic rhinitis

recurrent nose bleeds

recurrent sinusitis

trouble detecting odor

trachea (windpipe)

condition

nose polyps

sleep apnea

other nose or throat

condition

**Lung and Chest**

Yes No

coughing blood

lung or chest infection

pulmonary hypertension

active tuberculosis

emphysema (COPD)

chronic bronchitis

asthma or history of

childhood asthma

use of inhaler medications

lung surgery

chest wall surgery

pneumothorax (collapsed

lung)

diaphragm condition

interstitial lung disease

pulmonary vascular

disease

pulmonary embolism

bronchiectasis

cystic fibrosis

other lung or chest

condition

**Heart**

Yes No

coronary artery disease

myocardial infarction

(heart attack)

angina

heart valve condition

coronary angioplasty

cardiomyopathy

heart surgery

congestive heart failure

irregular heart beat

heart or chest pain

**Heart (con’t)**

Yes No

leg edema or swelling

heart inflammation

recurrent syncope (loss of

consciousness)

implanted defibrillator

ischemic heart disease

heart block or abnormal

EKG finding

pacemaker

enlarged heart

other heart condition

**Vascular**

Yes No

hypertension (high blood

pressure)

thoracic or aortic

aneurysm

carotid artery stenosis

peripheral vascular disease

claudication (leg pain with

walking)

Raynaud’s phenomenon or

disease

thrombophlebitis

varicose veins

blood clot in your legs

leg swelling

orthostatic hypotension

fast or slow heart beat

other vascular condition

**Abdomen or Gastrointestinal (GI)**

Yes No

groin hernia

abdominal wall hernia

gall bladder condition

gastritis (GERD)

bleeding of the stomach

or GI tract

hepatitis

inflammatory bowel

disease

irritable bowel syndrome

abdominal surgery

pancreatitis

colon or intestinal concern

diverticulosis, diverticulitis

stomach or GI ulcers

spleen condition

cirrhosis

other liver or abdominal

condition

**Metabolic Syndrome**

Yes No

Have you been told you

have metabolic syndrome

**Reproductive**

Yes No

are you pregnant

painful periods

endometriosis

ovarian cysts

other gynecological

concerns

testicular mass

epididymal mass

reproductive cancer

other reproductive

condition

**Urinary System**

Yes No

renal failure / insufficiency

peritoneal or hemodialysis

chronic kidney disease

other kidney disease

other bladder concern

other prostate concern

**Spine and Axial Skeleton**

Yes No

scoliosis

spine condition resulting in

weakness or numbness

radiculopathy

spine fracture

spinal instability

pain requiring narcotic

medication

nerve root damage

spinal disc concern

spinal dislocation

spine or disc surgery

congenital spinal condition

back or neck arthritis

spinal bone concerns

other abnormal curvature

of the neck or back

infection in the spine

other neck or spine

condition

**Extremities**

Yes No

joint replacement

any amputation

congenital absence of digit

use of assistive device

persistent or chronic pain

bone grafts

chronic sores

shoulder dislocation

**Extremities (con’t)**

Yes No

fractures

lack of full range of motion

any surgery of shoulders,

arms, elbows, hands,

fingers, hips, knees,

ankles, legs, or feet

unequal leg length

implants or hardware

other extremity condition

**Neurological**

Yes No

seizure

epilepsy

use of seizure medication

tremor

difficulty with walking

cerebral arteriosclerosis

transient ischemic attack

(TIAs or mini strokes)

stroke or cerebral vascular

accident (CVA)

paralysis

multiple sclerosis

myasthenia gravis

muscular dystrophy or

atrophy

cerebral aneurysm

dementia

Parkinson’s disease or

other movement disorders

narcolepsy

amyotrophic lateral

sclerosis (ALS)

migraine

congenital brain

malformation

subarachnoid or brain

hemorrhage (bleeding)

head injury resulting in

concussion or cerebral

contusion

other neurological

condition

**Skin**

Yes No

skin cancer

eczema

cystic acne

psoriasis

skin graft

cutaneous lupus

erythematosus

scleroderma

vasculitic skin condition

atopic dermatitis

contact dermatitis

Albinism, Darier’s disease,

ichthyosis, Marfan

syndrome,

neurofibromatosis, or

other genetic condition

urticaria or angioedema

other skin condition

**Blood or Blood-Forming Organs**

Yes No

hemorrhagic conditions

requiring transfusions

sickle cell disease

clotting disorders

anemia

leukopenia (low WBCs)

polycythemia vera

splenomegaly

thromboembolic disease

other hematological

condition

**Endocrine and Metabolic**

Yes No

Type I diabetes mellitus

Type II diabetes mellitus

use of insulin

adrenal gland condition

pituitary gland condition

parathyroid gland

condition

thyroid gland condition

other metabolic condition

other endocrine condition

**Systemic and Miscellaneous**

Yes No

connective tissue disease

dermatomyositis

systemic lupus

erythematosus

scleroderma

rheumatoid arthritis

burn with resulting

movement condition

heat illness

rhabdomyolysis

metabolic acidosis

exertion-related

Incapacitation

**Tumors and Malignant Disease**

Yes No

malignant disease newly

diagnosed, currently being

treated, or under active

surveillance

**Tumors and Malignant Disease (con’t)**

Yes No

benign tumors

CNS tumor or malignancy

head or neck malignancy

lung cancer

gastrointestinal

malignancy

genitourinary malignancy

bone or soft tissue

malignancy

hematological malignancy

other tumor or malignant

condition

**Psychiatric**

Yes No

current psychiatric

condition

current substance abuse

Condition

**Medications**

Yes No

narcotic or opioid

methadone

sedatives (anti-anxiety)

sleep aids

blood thinners

beta blockers (blood

pressure medication)

high dose diuretic (water

pill)

clonidine

inhaled bronchodilators

inhaled steroids

montelukast

high dose corticosteroids

anabolic steroids

tobacco products

alcohol consumption

heart medications

stimulants (ADHD

medication)

muscle relaxants

Please list all medications, including over the counter and dietary supplements: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list all surgeries and approximate dates: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Please list conditions for which you have seen a medical provider for the last five years: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you have any medical condition which you feel may interfere with your ability to do the job with or without accommodation?**  Yes  No

If yes, please describe: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**OCCUPATIONAL HISTORY**

Have you performed a job similar to the new one?  Yes  No If yes, for how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you worked in mining, foundry or smelting, underground, farming or logging industries?  Yes  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been exposed to the following substances either at work or at home (hobbies):

Dust/Smoke  Yes  No

Fumes/Mists  Yes  No

Asbestos/Silica  Yes  No

Radiation  Yes  No

Pesticides  Yes  No

Infectious agents  Yes  No

Noise  Yes  No

Heavy Metals  Yes  No

Chemicals/Solvents  Yes  No

Latex allergy  Yes  No