**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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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

**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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**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