**Subject Initials \_\_\_ \_\_\_ \_\_\_ Subject ID \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ Date: \_\_\_ \_\_\_** **/\_\_ \_\_ \_\_ / \_\_ \_\_**

Day Month Year

# Medical History (General)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Body System\*** | **Diagnosed condition?** | **Diagnosis/Condition/Surgery** | **Onset Date Or Year** | **Current Problem** |
| Eyes | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Ears, nose, mouth and throat (ENT) | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Cardiovascular | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Respiratory | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Gastrointestinal | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Genitourinary | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |

**Subject Initials \_\_\_ \_\_\_ \_\_\_ Subject ID \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ Date: \_\_\_ \_\_\_** **/\_\_ \_\_ \_\_ / \_\_ \_\_**

Day Month Year

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Body System\*** | **Diagnosed condition?** | **Diagnosis/Condition/Surgery** | **Onset Date Or Year** | **Current Problem** |
| Musculoskeletal | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Integumentary / Breast | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Neurological | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Psychiatric | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Endocrine | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Hematologic / Lymphatic | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Allergic / Immunologic | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
| Other (specify) | **□** Yes **□** No |  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |
|  |  | **□** Yes **□** No |

*\*13 of the 14 body systems recognized by the Centers for Medicare and Medicaid Services (14th is constitutional symptoms)*

**ADDITIONAL NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□** *Medical History*

*Not Obtained*

**MEDICAL HISTORY OBTAINED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**