Allergy Medical Group
of the North Area, Inc.
The experience you trust for the relief you need

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REVIEW OF SYSTEMS

Name _____ Date _____

Hospitalizations _____

Date	*Hospital*	*Reason for Hospitalization*

Surgeries _____

Date	*Hospital*	*Operation*

Serious Illnesses _____

Date	*Illness/Injury*	*Outcome*

Conditions (check all that apply) _____

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ HIV Positive
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Prostrate Problems
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

NEUROLOGICAL *Have you ever had?* _____

❑ Frequent headaches ❑ Loss of consciousness ❑ Seizures/Convulsions ❑ Stroke ❑ Paralysis

INFECTIONS *Have you ever had?* _____

❑ Measles ❑ Mumps ❑ Chicken Pox ❑ Whooping Cough ❑ Diphtheria

OB/GYN *Have you ever had?* _____

❑ Hysterectomy ❑ Breast Tumor/Cyst ❑Pregnancies (#) _____ Date of last menstrual cycle? _____