

# Appendix D

## HISTORY TEMPLATE

BASIC SCHEME	REVIEW OF SYSTEMS	
<b>CHIEF COMPLAINT:</b>  <b>HISTORY OF PRESENT ILLNESS:</b> Onset Position/posture Previous history Progression Quality Radiating Severity Temporal factors Treatment Understanding  Aggravating Alleviating Associated symptoms  <b>Etiologies</b> <b>Risk factors</b> <b>Complications</b>  How has illness affected your life Support systems Worries, fears Expectations	<b>CONSTITUTIONAL:</b> <input type="checkbox"/> Weight $\Delta$ <input type="checkbox"/> Energy <input type="checkbox"/> Fever, chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Appetite $\Delta$ <input type="checkbox"/> Sleep <input type="checkbox"/> Mood $\Delta$  <b>HEAD AND NECK:</b> <input type="checkbox"/> Vision $\Delta$ <input type="checkbox"/> Diplopia $\Delta$ <input type="checkbox"/> Smell <input type="checkbox"/> Rhinorrhea <input type="checkbox"/> Sinusitis <input type="checkbox"/> Epistaxis <input type="checkbox"/> Hearing $\Delta$ <input type="checkbox"/> Discharge <input type="checkbox"/> Tinnitus <input type="checkbox"/> Vertigo <input type="checkbox"/> Sore throat <input type="checkbox"/> Teeth <input type="checkbox"/> Tongue <input type="checkbox"/> Oral lesions <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck mass  <b>CARDIAC:</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Dyspnea <input type="checkbox"/> Syncope <input type="checkbox"/> Palpitations <input type="checkbox"/> Orthopnea <input type="checkbox"/> PND <input type="checkbox"/> Claudication <input type="checkbox"/> Leg edema <input type="checkbox"/> Murmurs <input type="checkbox"/> Hypertension <input type="checkbox"/> Rheumatic fever  <b>RESPIRATORY:</b> <input type="checkbox"/> Dyspnea <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Pleuritic chest pain  <b>GASTROINTESTINAL:</b> <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia <input type="checkbox"/> Heartburn <input type="checkbox"/> Reflux <input type="checkbox"/> N&V <input type="checkbox"/> Hematemesis <input type="checkbox"/> Melena <input type="checkbox"/> Abd pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bowel habits <input type="checkbox"/> Hematochezia <input type="checkbox"/> Bloating <input type="checkbox"/> Flatus <input type="checkbox"/> Pale stool <input type="checkbox"/> Jaundice <input type="checkbox"/> Hemorrhoid	<b>RHEUMATOLOGIC:</b> <input type="checkbox"/> Joint pain, swelling, redness <input type="checkbox"/> AM stiffness <input type="checkbox"/> Back pain <input type="checkbox"/> Myalgia <input type="checkbox"/> Arthralgia <input type="checkbox"/> Skin rash <input type="checkbox"/> Raynaud's <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry mouth <input type="checkbox"/> Oral ulcers <input type="checkbox"/> Hair loss <input type="checkbox"/> Photosensitivity <input type="checkbox"/> Psoriasis <input type="checkbox"/> IBD  <b>Obs/Gyn:</b> <input type="checkbox"/> Menarche age <input type="checkbox"/> LMP <input type="checkbox"/> Cycle regular <input type="checkbox"/> Period length <input type="checkbox"/> Periods freq. <input type="checkbox"/> Period volume <input type="checkbox"/> Menopause age <input type="checkbox"/> HRT <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> No. of preg. <input type="checkbox"/> Difficult preg. <input type="checkbox"/> Contraception <input type="checkbox"/> STDs <input type="checkbox"/> Vaginal dryness or discharge <input type="checkbox"/> Dyspareunia  <b>BREASTS:</b> <input type="checkbox"/> Masses <input type="checkbox"/> Swelling <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Pain <input type="checkbox"/> Self breast exam  <b>ENDOCRINE:</b> <input type="checkbox"/> Polydipsia <input type="checkbox"/> Polyphagia <input type="checkbox"/> Polyuria <input type="checkbox"/> Galactorrhea <input type="checkbox"/> Heat or cold tolerance  <b>NEUROPSYCHIATRIC:</b> <input type="checkbox"/> Unconscious <input type="checkbox"/> Syncope <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Memory loss <input type="checkbox"/> Dysphasia <input type="checkbox"/> Head trauma <input type="checkbox"/> Strokes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Paresis <input type="checkbox"/> Clumsiness <input type="checkbox"/> Balance/gait  <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal <input type="checkbox"/> Anxiety <input type="checkbox"/> Previous $\psi$ hx  <b>SKIN:</b> <input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Pruritus <input type="checkbox"/> Pigment $\Delta$
<b>PAST MEDICAL HISTORY:</b> <b>Hospitalization</b> (time, tx, recovery) <b>Medical illnesses</b> (time, tx, recovery) <b>Injuries</b> (time, tx, recovery)  <b>MEDICATIONS:</b> drug name, dose, route, frequency  <b>ALLERGIES:</b>  <b>IMMUNIZATIONS:</b>	<b>GENITOURINARY:</b> <input type="checkbox"/> Dysuria <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Hesitancy <input type="checkbox"/> Incontinence <input type="checkbox"/> Slow stream <input type="checkbox"/> Hematuria <input type="checkbox"/> Nocturia <input type="checkbox"/> Discharge <input type="checkbox"/> Libido <input type="checkbox"/> Impotence	
<b>SOCIAL HISTORY:</b> <input type="checkbox"/> Living arrangement, marital <input type="checkbox"/> Support system <input type="checkbox"/> Hobbies  <input type="checkbox"/> ADLs <input type="checkbox"/> IADLs <input type="checkbox"/> Education <input type="checkbox"/> Occupation  <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Diet		
<b>FAMILY HISTORY:</b> <b>Father</b> <b>Mother</b> Siblings      Children <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease		
<b>REMARKS:</b>		