JON MCLENNAN, M.D.

PATIENT NAME: _____ AGE: _____

HISTORY OF PRESENT ILLNESS/INJURY: _____

_____

_____

SUBJECTIVE COMPLAINTS: ____ Locking ____ Giving way ____ Swelling
____ Numbness ____ Pain ____ Tingling
____ Redness ____ Cramping ____ Weakness
____ Stiffness ____ Instability
____ Other: _____

_____

_____

ALLERGIES _____

MEDICAL HISTORY: ____ BP ____ HEART ____ LUNG ____ KIDNEY
____ ARTHRITIS ____ STOMACH ____ CANCER
____ DIABETES

SURGICAL HISTORY: _____

MEDICATIONS: _____

FAMILY HISTORY: ____ BP ____ HEART ____ LUNG ____ KIDNEY
____ ARTHRITIS ____ STOMACH ____ CANCER
____ DIABETES

SOCIAL HISTORY: OCCUPATION _____
____ MARRIED ____ DIVORCED ____ WIDOWED
____ CIGARETTES/CIGARS ____ ALCOHOL

REVIEW OF SYSTEMS: DESCRIBE ANY PROBLEMS YOU MAY HAVE IN THE FOLLOWING CATEGORIES.

HEAD, EYES, EARS, NOSE, THROAT _____

_____

CHEST, LUNGS, BREAST _____

_____

HEART _____

ABDOMEN _____

EXTREMITIES _____

NEUROLOGICAL _____