Picture 10. Nuclear Medical History Recording Form

Name ____
Medical Record Number ____
Date of obtaining history ____

Instructions to examiner. Please neatly write answers to all items. Please record all positive findings. Please then neatly sign and date the form.

Date of birth ____
Sex ____
Reason for visit ____
____
____
____
History of present illness ____
____
____
____
Past medical history ____
____
____
____
Illnesses ____
____
____
____
Operations ____
____
____
____
Hospitalizations ____
____
____
____
Current medications ____
____
____
____
Allergies____
____
____
____
Occupation ____
____
____

Social history ____

Alcohol use ____

Substance (recreational, nonprescribed, illegal drugs) use ____________________

Caffeine use ____

Nicotine use ____

Review of Systems

Head ____

Eyes ____

Ears ____

Nose ____

Mouth ____

Throat ____
____
____
____
Respiratory ____
____
____
____
Cardiovascular ____
____
____
____
Digestive ____
____
____
____
Endocrine ____
____
____
____
Hematologic ____
____
____
____
Urinary ____
____
____
____
Genital ____
____
____
____
Neuropsychiatric ____
____
____
____

Printed name of examiner ____
Signature of examiner ____
Date ______________________