Personal Pathological History

Patient Name:_____ Date: ___/___/___

Cardiovascular System

High Blood Pressure: Yes___ No___
Coronary Heart Disease:Yes___ No___
Peripheral Vascular Disease:Yes___ No___
Cardiac Insufficiency: Yes___ No___
Rheumatic Heart Disease: Yes___ No___
Congenital Heart Disease: Yes___ No___

Other:_____

Endocrine System

Diabetes : Yes___ No___
Hyperthyroidism : Yes___ No___
Hypothyroidism: Yes___ No___
Asthenia: Yes___ No___
Adynamia: Yes___ No___
Hyperactivity Yes___ No___

Other:_____

Hematological Disease

Anemia: ___ Haemophilia ___
Leukemia: ___ Pallor: ___
Adenomegaly: ___ Bleeding: ___
Fatigue: ___ Petechia: ___

Other:_____

Oncology

Thyroid Cancer: ___
Colon Cancer: ___
Lung Cancer: ___
Prostate Cancer: ___
Ovary Cancer: ___
Breast Cancer: ___
Other:_____

Neurological System

Strokes: ___
Alzheimers: ___
Parkisons: ___
Tension Headaches: ___
Migraine Headaches: ___
Epilepsy: ___
Brain Tumors: ___
Dementia: ___
Other:_____

Respiratory System

Rhinitis: ___ Pharyngitis: ___
Tonsillitis: ___ Bronchitis: ___
Emphysema: ___ Asthma: ___
Chronic Cough: ___ Tuberculosis: ___
Nose Bleed: ___ Cyanosis: ___
Dyspnea: ___

Other:_____

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