

REVIEW OF SYSTEMS:

DRUG ALLERGIES & REACTIONS

CURRENT MEDICATIONS

Important: The following form is intended to gather information that could be very important to your health. Please take the time to carefully and completely answer all of the questions on this form. We appreciate your cooperation. Thank you.

Do you have any questions, problems, symptoms or concerns that you would like to discuss with us today?

Do you have now or have you had within the past year:

CONST **NO** **YES**

Weight gain/loss

Fever

Fatigue

EYES

Dry eyes

Vision changes

ENT

Mouth sores

Sore throat

Ringing in ears

Sinus headaches

Persistent cough

Coughing blood

Wheezing

CV

Shortness of breath

Short of breath with activity

Difficulty breathing

lying down

Chest pain

Rapid heart beat

Swollen hands/feet

SKIN

Skin rash

Painful breast

GI/GU/GYN

Persistent diarrhea

Bloody stools

Nausea/vomiting

Constipation

Bloating/gas

Abdominal pain

Frequent urination

ageUrine leak

Painful urination

Age periods started

CONTINUED **NO** **YES**

Date of Last Pap

Any abnormal Paps

Date of Last Mammo

Self breast exam

Breast lump

or discharge

Breast feed

Vaginal discharge

ALLERGIES

Hives/blisters

Red, itchy eyes

Persistent sore throat

PSYCH

Depression

Mood swings

Sleep disturbance

NEURO

Seizures

Frequent headaches

Dizziness

Numbness

MSK

Joint or muscle pain

Muscle weakness

LYMPH

Swollen lymph nodes

HEME

Easy bleeding

ENDO

Easy Bruising

Night sweats

Intolerance to heat

Cold intolerance

Past Medical History

Have you ever had the following:

CONDITION	NO	YES	COMMENTS	CONDITION	NO	YES	COMMENTS
Aids or HIV+				Heart Disease			
STD				Hepatitis			
Allergies				High BP			
Anemia				Kidney Disease			
Arthritis				Rheumatic Fever			
Asthma				Stomach Ulcer			
Bleeding tendency				Stroke			
Breast Cancer				Thyroid Disease			
Skin Cancer				Tuberculosis			
Other Cancer				Other			
Diabetes							
Glaucoma				Colonoscopy procedure			Date: _____

Past History continued Non-Contributory No Interval Change since ____ / ____ / ____

Surgeries: _____

Illnesses: _____

Number of pregnancies _____

Live births _____

Vaginal delivery _____

Cesarean delivery _____

Patient Social History

Occupation:	Have you ever been sexually abused? No Yes
Weight: Height:	Are you being treated for anxiety or depression? No Yes
Do you exercise?	Are you being treated for other mental illnesses? No Yes
Type of exercise?	Do you get calcium in your diet? No Yes
How often?	Supplements:
Smoking (type and amount per day)	Alcohol (type and amount per week):
If former smoker, date quit:	Do you use marijuana, cocaine or other drugs?
Marital Status: Single Married Widowed Divorced	

Patient's Family History

Has any blood relative ever had the following:

CONDITION	NO	YES	COMMENTS	CONDITION	NO	YES	COMMENTS
Arthritis				Blood Clots			
Breast Cancer				Heart Disease			
Colon Cancer				High BP			
Uterine Cancer				Kidney Disease			
Ovarian Cancer				Stroke			
Other Cancer				Tuberculosis			
Depression				Osteoporosis			
Diabetes				Other			
Hepatitis							

The information I have provided on this form is accurate and complete to the best of my knowledge:

Signature of patient or parent if minor

Date

Provider's Signature

Date