Personal/ Family / Social History / Review of Systems

Patient sticker

Date: ________________ Age: ________

Fill in dates of most recent:

Last Menstrual Period ________

Pap Smear ________

Mammogram ________

Colonoscopy ________

Bone Density ________

Cholestrol ________

Hm. ph. #: ____________ Wk ph. #: ____________ Cell ph. #: ____________

Primary M.D. ____________________ Other M.D.s ____________________

Birth control method/medication or hormone medication ____________________

Please list all other medications ❑ None
(name / dose / frequency)

____

____

Drug Allergies: ❑ None
(name / reaction)

____

____

Since your last appointment, have you: (Answer yes or no and Explain)

had any serious illnesses, operations, injuries, or have you been hopitalized? ____________

discovered any additional information about your family history that we should know? ____________

changed smoking / drinking / drug use / marital status / occupation? ____________

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

System	None	Symptoms
1. Constitutional:	❑ None	❑ Weight loss ❑ Weight gain ❑ Fever ❑ Fatigue
2. Eyes:	❑ None	❑ Vision change ❑ Glasses/contacts
3. Ears, Nose, Throat/Mouth:	❑ None	❑ Ulcers ❑ Sinus drainage or infection ❑ Ringing in Ears ❑ Headaches
4. Cardiovascular:	❑ None	❑ Shortness of breath lying down ❑ Chest pain ❑ Shortness of breath on exertion ❑ Swelling ❑ Palpitation or irregular heart beat
5. Respiratory:	❑ None	❑ Wheezing ❑ Coughing up blood ❑ Shortness of breath ❑ Cough
6. Gastrointestinal:	❑ None	❑ Diarrhea ❑ Bloody Stool ❑ Nausea / vomiting ❑ Constipation ❑ Excessive Flatulence ❑ Pain
7. Genitourinary:	❑ None	❑ Blood in Urine ❑ Burning with Urination ❑ Urinary Urgency ❑ Urinary Frequency ❑ Incomplete Urinary Emptying ❑ Urinary Incontinence ❑ Abnormal Bleeding ❑ Pain with Intercourse ❑ Menstrual Cramps ❑ Abnormal Vaginal Discharge
8. Musculoskeletal:	❑ None	❑ Muscle weakness ❑ Muscle or Joint Pain
9. Skin/breast:	❑ None	❑ Breast Tenderness ❑ Nipple Discharge ❑ Breast Mass ❑ Rash ❑ Ulcers ❑ Pigmented Skin Lesions
10. Neurological:	❑ None	❑ Fainting ❑ Seizures ❑ Numbness ❑ Trouble walking ❑ Severe Memory Prob
11. Psychiatric:	❑ None	❑ Depression ❑ Crying ❑ Severe Anxiety
12. Endocrine:	❑ None	❑ Diabetes ❑ Hypothyroid ❑ Hyperthyroid ❑ Hot Flashes ❑ Hair loss ❑ Heat / Cold Intolerance
13. Hematological / Lymphatic:	❑ None	❑ Bruises Easily ❑ Bleeds Easily ❑ Swollen Lymph Glands
14. Allergies:	❑ None	

YOUR SIGNATURE: ______________________ DATE: ____________