Review of Systems Today's Date: _____

Patient Name:_____ **Date of Birth:**_____

Where do you currently reside? (Circle one) Independently In an Assisted Living Facility In a Nursing Home

Gastrointestinal

Nausea	No Yes
Vomiting	No Yes
Heartburn	No Yes
Food sticking in throat	No Yes
Painful swallowing	No Yes
Vomiting blood	No Yes
Black stool	No Yes
Red blood in stool	No Yes
Abdominal pain	No Yes
Constipation	No Yes
Diarrhea	No Yes
Loss of appetite	No Yes
Early satiety (feeling full fast)	No Yes
Bloating	No Yes

HEENT

Sore throat	No Yes
Hoarseness	No Yes

Cardiovascular

Abnormal heart rhythm	No Yes
Chest pain	No Yes
Palpitations	No Yes

Respiratory

Cough	No Yes
Shortness of breath on exertion	No Yes
Shortness of breath at rest	No Yes
Wheezing	No Yes

Neurological

Seizures	No Yes
Headaches	No Yes

Dermatology

Rash	No Yes

Musculoskeletal

Joint pain	No Yes
Arthritis	No Yes

Psychiatric

Dementia	No Yes
Depression	No Yes
Anxiety	No Yes

Constitutional

Recent weight gain # of pounds _____	No Yes
Recent weight loss # of pounds _____	No Yes
Fever	No Yes
Fatigue	No Yes

Genitourinary

Frequent urination	No Yes
Kidney failure/dialysis	No Yes
Painful urination	No Yes
Date of last menstrual period _____	

Are you taking any blood thinners (Coumadin, Warfarin, Plavix, Pletal, Pradaxa, etc.) NO__ YES__

Current Medication-Please list all prescription and over the counter medicines including doses

Medical History

Ascites (extra fluid in abdomen)	No Yes	High Blood Pressure	No Yes
Asthma	No Yes	Kidney Failure	No Yes
Bleeding Disorder	No Yes	Kidney Stones	No Yes
Cancer What type _____	No Yes	Liver Disease	No Yes
Congestive Heart Failure (CHF)	No Yes	Migraine Headaches	No Yes
Coronary Artery Disease (CAD)	No Yes	Pancreatitis	No Yes
Depression	No Yes	Peripheral Vascular Disease	No Yes
Diabetes	No Yes	Rheumatic Fever	No Yes
Emphysema or COPD	No Yes	Seizures	No Yes
Endometriosis	No Yes	Sleep Apnea	No Yes
Gallstones	No Yes	Stomach Ulcer	No Yes
Heart Arrythmia (A. Fib/ SVT/ A.Flutter)	No Yes	Stroke/TIA	No Yes
Heart Attack	No Yes	Thyroid Disease	No Yes
Hepatitis	No Yes	Valvular Heart disease orEndocarditis	No Yes

_____reviewed w/ patient

04/24/2014

Patient Name:_____Date of Birth: ____/____/____

Drug Allergies/Intolerance

Past Surgical History

Abdominal Surgery	No Yes	**Gallbladder Removal**	No Yes
What type_____		**Heart Valve Replacement**	No Yes
Appendectomy	No Yes	**Hemorrhoid Removal**	No Yes
Cancer Surgery	No Yes	**Hip, Shoulder, Knee replacement within 1 year**	No Yes
What type _____			
Coronary Artery Bypass (CABG)	No Yes	Hysterectomy (TAH)	No Yes
Coronary Stent	No Yes	**Laparoscopy**	No Yes
Cosmetic Surgery	No Yes	**Pacemaker**	No Yes
What type _____		**Salpingoophorectomy (BSO)**	No Yes
Defibrillator	No Yes	(tube and ovary removal)	
If yes, we need a copy of the card		**Tonsillectomy**	No Yes
		Vascular Bypass/grafts within 1 yr	No Yes

Hospitalizations (non-surgical)

_____

_____

Family Medical History (not you) If Yes, please list the relative and age

Colon Cancer	No Yes	_____
Colon Polyps	No Yes	_____
Inflammatory Bowel Disease (IBD)	No Yes	_____
Cancer of:		
Endometrial	No Yes	_____
Esophagus	No Yes	_____
Kidney	No Yes	_____
Ovarian	No Yes	_____
Pancreas	No Yes	_____
Small Bowel	No Yes	_____
Stomach	No Yes	_____

Social History

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Children: No _____ Yes _____ How many? _____

Use of Alcohol: None _____ Yes _____ How much? _____

Use of Tobacco: Never _____ Quit _____ Yes _____ How much? _____

Employer and Occupation: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

_____

Signature of patient **Date**