Review of Systems/Medical and Family History Update

Patient Name: ______________________ Date: ______________

Required questions for insurance compliance

Do you have an advance directive? .... no yes

Are you a victim of violence or abuse? .... no yes

Had a flu shot this year? .... no yes

Had a pneumonia shot? .... no yes

NAME OF PRIMARY CARE PROVIDER (for correspondence):____

HAVE YOU OR MEMBERS OF YOUR FAMILY RECENTLY BEEN HOSPITALIZED FOR ANY REASON? NO YES

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Good general health lately .... no yes

Recent weight change .... no yes

Fever .... no yes

Fatigue .... no yes

Eyes and vision

Eye disease or injury .... no yes

Wear glasses or contact lenses .... no yes

Blurred or double vision .... no yes

Glaucoma .... no yes

Ears, nose, throat

Hearing loss .... no yes

Ringing in the ears .... no yes

Earaches or drainage .... no yes

Sinus problems .... no yes

Nose bleeds .... no yes

Mouth sores .... no yes

Bleeding gums .... no yes

Bad breath or bad taste .... no yes

Sore throat or voice change .... no yes

Swollen glands in neck .... no yes

Heart and Cardiovascular

Heart trouble .... no yes

Chest pains .... no yes

Sudden heartbeat changes .... no yes

Swelling of feet, ankles, hands .... no yes

Respiratory

Frequent coughing .... no yes

Spitting up blood .... no yes

Shortness of breath .... no yes

Asthma or wheezing .... no yes

Gastrointestinal

Loss of appetite .... no yes

Change in bowel movements .... no yes

Nausea or vomiting .... no yes

Frequent diarrhea .... no yes

Painful bowel movements or constipation .... no yes

Blood in stool .... no yes

Stomach pain .... no yes

Genitourinary

Frequent urination .... no yes

Burning or painful urination .... no yes

Blood in urine .... no yes

Change in force or strain with urination .... no yes

Incontinence or dribbling .... no yes

Kidney stones .... no yes

Sexual difficulty .... no yes

Painful periods .... no yes

Irregular periods .... no yes

Vaginal discharge .... no yes

Musculoskeletal

Joint pain .... no yes

Joint stiffness or swelling .... no yes

Weakness of muscles/joints .... no yes

Muscle pain or cramps .... no yes

Back pain .... no yes

Cold extremities .... no yes

Difficulty in walking .... no yes

Skin and breasts

Rash or itching .... no yes

Change in skin color .... no yes

Change in hair or nails .... no yes

Varicose veins .... no yes

Breast pain .... no yes

Breast lump .... no yes

Breast discharge .... no yes

Neurological

Frequent or recurrent headaches .... no yes

Light headed or dizzy .... no yes

Convulsions or seizures .... no yes

Numbness or tingling sensations .... no yes

Tremors .... no yes

Paralysis .... no yes

Stroke .... no yes

Head injury .... no yes

Psychiatric

Memory loss or confusion .... no yes

Nervousness .... no yes

Depression .... no yes

Sleep problems .... no yes

Endocrine

Glandular or hormone problem .... no yes

Thyroid disease .... no yes

Diabetes .... no yes

Excessive thirst or urination .... no yes

Heat or cold intolerance .... no yes

Dry skin .... no yes

Change in hat or glove size .... no yes

Hematologic/Lymphatic

Slow to heal after cuts .... no yes

Easily bruise or bleed .... no yes

Amemia .... no yes

Phlebitis .... no yes

Transfusion .... no yes

Swollen glands .... no yes

If you have not had a hysterectomy, please give the date of your last menstrual period______________________

Patient sign here:______________________

Physician/PA sign here: ______________________

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