Date:_____

Name:_____ Date Of Birth: _____/_____/_____

Chief Complaint:_____

Please Circle All That Apply

**Past Medical History:** Diabetes, High Blood Pressure, High Cholesterol, Kidney Stones, Blood Clots in Legs or Lungs, Heart Attack, Kidney Failure, Cancer and Type:_____
OTHER Medical Problems:_____
_____

**Past Surgical History:** Hysterectomy, Gall Bladder Removal, Tonsillectomy, Appendectomy, Heart Bypass, Cardiac Stent, Ureteroscopy for Stones, Shock Wave Lithotripsy (ESWL), Kidney Removal, Prostate Removal

OTHER Surgeries:_____
Mammography (Age 41 to 69) YES/NO Date_____
Colonoscopy (Age 50 or older) YES/NO Date_____
Dexascan for Osteoporosis (age 60 or old older) YES/NO Date_____
**Immunizations:** Flu Vaccination YES/NO Date_____
Pneumonia Vaccination (Age 65 or older) YES/NO Date_____

**Medicines/Doses:** _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

**Allergies/Reaction:** _____ _____ _____
_____ _____ _____ _____

**Smoking History:**
Packs Per Day:_____ How Many Years:_____ Quit? If so, when?_____

**Alcohol Use:** _____ **IV Drug Use:** _____

**Family Health Problems:** Diabetes, High Blood Pressure, High Cholesterol, Kidney Stones, Blood Clots in Legs or Lungs, Heart Attack, Kidney Failure, Cancer and Type:_____
OTHER Family Health Problems:_____

**Vitals:**
HT _____
WT _____
BP _____
HR _____

**Pharmacy / Location:**_____

**Referring Physician:**_____

**Primary Care Physician:**_____

Date:_____

Name:_____ Date Of Birth:_____/_____/_____

# Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.
**Please explain any Yes answers in the space provided.**

**Genitourinary**

| | | |
|---|---|---|
| Urine Retention | Y | N |
| Painful Urination | Y | N |
| Urinary Frequency | Y | N |

Other_____

**Eyes**

| | | |
|---|---|---|
| Blurred Vision | Y | N |
| Double Vision | Y | N |
| Pain | Y | N |

Other_____

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear Infection | Y | N |
| Sore Throat | Y | N |
| Sinus Problems | Y | N |

Other_____

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | Y | N |
| Varicose Veins | Y | N |
| High Blood Pressure | Y | N |

Other_____

**Respiratory**

| | | |
|---|---|---|
| Shortness of Breath | Y | N |
| Wheezing | Y | N |
| Frequent Cough | Y | N |

Other_____

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal Pain | Y | N |
| Constipation | Y | N |
| Nausea/Vomiting | Y | N |
| Indigestion/Heartburn | Y | N |

Other_____

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | Y | N |
| Neck Pain | Y | N |
| Back Pain | Y | N |

Other_____

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | Y | N |
| Boils | Y | N |
| Persistent Itch | Y | N |

Other_____

**Neurological**

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy Spells | Y | N |
| Numbness | | |
| Tingling | Y | N |

Other_____

**Psychiatric**

| | | |
|---|---|---|
| Depression | Y | N |
| Anxiety | Y | N |
| Life Satisfaction | Y | N |
| Suicidal | Y | N |

Other_____

**Endocrine**

| | | |
|---|---|---|
| Excessive Thirst | Y | N |
| Too Hot | Y | N |
| Too Cold | Y | N |
| Fatigue | Y | N |

Other_____

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen Glands | Y | N |
| Bleeding Disorders | Y | N |

Other_____

**Allergic/Immunologic**

| | | |
|---|---|---|
| Hay Fever | Y | N |
| Drug Allergies | Y | N |

Other_____

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |

Other_____