Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

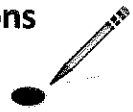
# Review of Systems

Please answer every question

To reproduce, follow the printing instructions. Fold only on the dotted lines.

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

**Please mark all symptoms you are CURRENTLY experiencing. Mark all that apply.**

**If you have no symptoms in a category, please mark "NONE".**

| | | | | |
|---|---|---|---|---|
| **GENERAL** | chills ◯ | fatigue ◯ | night sweats ◯ | |
| | fever ◯ | loss of appetite ◯ | weight gain ◯ | |
| | | | weight loss ◯ | **NONE** ◯ |
| **SKIN** | | hives ◯ | rash ◯ | |
| | change in wart or mole ◯ | jaundice ◯ | skin ulcer ◯ | |
| | dry skin ◯ | new sore/lesion ◯ | poor wound healing ◯ | **NONE** ◯ |

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| | | | | |
|---|---|---|---|---|
| **HEENT (Head, Eyes, Ears, Nose, Throat)** | earache ◯ | hoarseness ◯ | seasonal allergies ◯ | |
| | ear ringing ◯ | nose bleeds ◯ | sinus pain ◯ | |
| | hearing loss ◯ | oral ulcers ◯ | sore throat ◯ | |
| | glasses/contacts ◯ | visual disturbances ◯ | yellow eyes ◯ | **NONE** ◯ |
| **RESPIRATORY** | | coughing blood ◯ | snoring ◯ | |
| | chronic cough ◯ | difficulty breathing ◯ | wheezing ◯ | **NONE** ◯ |
| **BREAST** | | breast pain ◯ | mass/lump ◯ | |
| | | breast skin change ◯ | nipple discharge ◯ | **NONE** ◯ |
| **CARDIOVASCULAR** | | | difficulty breathing lying down ◯ | |
| | | chest pain ◯ | palpitations ◯ | |
| | | racing heart rate ◯ | shortness of breath ◯ | |
| | | leg cramps ◯ | swelling hands/feet ◯ | **NONE** ◯ |
| **GASTROINTESTINAL** | | constipation ◯ | hemorrhoids ◯ | |
| | abdominal pain ◯ | change in bowel habits ◯ | indigestion ◯ | |
| | bloating ◯ | difficulty swallowing ◯ | nausea ◯ | |
| | bloody stool ◯ | excessive gas ◯ | rectal pain ◯ | |
| | chronic diarrhea ◯ | getting full early ◯ | vomiting ◯ | **NONE** ◯ |
| **GENITOURINARY (Men Only)** | | blood in urine ◯ | painful urination ◯ | |
| | | change in urinary stream ◯ | urinary frequency ◯ | |
| | | excessive urination at night ◯ | urinary urgency ◯ | |
| | | impotence ◯ | urinary leakage ◯ | **NONE** ◯ |

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| | | | | |
|---|---|---|---|---|
| **GENITOURINARY (Women Only)** | | | pelvic pain ◯ | |
| | excessive urination at night ◯ | | urinary frequency ◯ | |
| | painful urination ◯ | | urinary urgency ◯ | **NONE** ◯ |
| **MUSCULOSKELETAL** | back pain ◯ | muscle pain ◯ | stiffness ◯ | |
| | joint pain ◯ | muscle weakness ◯ | swelling ◯ | **NONE** ◯ |
| **NEUROLOGIC** | | numbness ◯ | headaches ◯ | |
| | confusion/ decreased memory ◯ | seizures ◯ | fainting ◯ | |
| | | tingling ◯ | trouble walking ◯ | |
| | | tremors ◯ | weakness ◯ | **NONE** ◯ |
| **PSYCHIATRIC** | anxiety ◯ | bipolar ◯ | fearful ◯ | |
| | change in sleep pattern ◯ | depression ◯ | frequent crying ◯ | **NONE** ◯ |
| **ENDOCRINE** | cold intolerance ◯ | hair changes ◯ | hot flashes ◯ | |
| | excessive hunger ◯ | heat intolerance ◯ | new diabetes ◯ | **NONE** ◯ |
| **HEME/LYMPHATIC** | blood thinners ◯ | HIV ◯ | gland problems ◯ | |
| | easy bruising ◯ | excessive bleeding ◯ | persistent infection ◯ | **NONE** ◯ |

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Direction of Feed

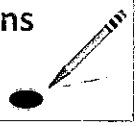
# Patient History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.*

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH: Month / Day / Year

## PAST MEDICAL HISTORY

**Please indicate if YOU have had any of the following. Mark all that apply.**

- ◯ **NONE**
- ◯ Acid Reflux / GERD
- ◯ Alcohol Abuse
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Back Pain
- ◯ Heart Failure
- ◯ Heart Murmur
- ◯ Hemorrhoids
- ◯ Hepatitis
- ◯ Hernia (inguinal)
- ◯ Hernia (umbilical)
- ◯ Hernia (ventral)
- ◯ High Blood Pressure
- ◯ Stomach Ulcer
- ◯ Stroke / TIA
- ◯ Thyroid Problems
- ◯ Ulcerative Colitis
- ◯ Vascular Disease
- ◯ **Other Significant Medical Illness:** _____

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- ◯ Bladder Problems
- ◯ Breast Mass
- ◯ Chest Pain
- ◯ Cirrhosis
- ◯ Crohn's Disease
- ◯ COPD
- ◯ Depression
- ◯ Diabetes
- ◯ Diverticulosis
- ◯ Emphysema
- ◯ Enlarged Prostate
- ◯ Gallstones
- ◯ Heart Attack
- ◯ High Cholesterol
- ◯ History of Blood Transfusions
- ◯ HIV Positive
- ◯ Home Oxygen Use
- ◯ Kidney Failure
- ◯ Kidney Stones
- ◯ Migraines
- ◯ Pancreatitis
- ◯ Problems with Anesthesia
- ◯ Pulmonary Embolism / Blood Clot in Legs
- ◯ Seizures
- ◯ Sickle Cell Disease
- ◯ Sleep Apnea

**Cancer:**

- ◯ Breast
- ◯ Cervical
- ◯ Colon
- ◯ Lung
- ◯ Melanoma / Skin
- ◯ Ovarian
- ◯ Pancreatic
- ◯ Prostate
- ◯ Rectal
- ◯ Thyroid
- ◯ Other Cancer: _____

**Have you had a colonoscopy:** ◯ within last year ◯ 1-5 years ago ◯ 5-10 years ago ◯ >10 years ago ◯ never

## REPRODUCTIVE HISTORY (WOMEN ONLY)

**Age at first period:** ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17

**Are your periods regular?** ◯ yes ◯ no

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**Contraceptive history:** ◯ oral contraceptive pills ◯ contraceptive injection ◯ contraceptive implant ◯ progesterone IUD

**If you have gone through menopause, what age were you?** ◯ <45 ◯ 46-50 ◯ 51-55 ◯ 56-60 ◯ >60

**Number of pregnancies:** ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

**Number of live births** ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

**Age at first pregnancy:** ◯ <15 ◯ 15-20 ◯ 21-25 ◯ 26-30 ◯ 31-35 ◯ 36-40 ◯ >40

**If you had children and breastfed them, how many months did you breastfeed?** ◯ 3-6 ◯ 7-12 ◯ 12-24 ◯ >24

**Have you had a mammogram:** ◯ within last year ◯ 1-3 years ago ◯ >3 years ago ◯ never

**Have you had a pap smear:** ◯ 1-5 years ago ◯ >5 years ago ◯ never

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Direction of Feed

# Patient History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.*

## SOCIAL HISTORY

| | | |
|---|---|---|
| **Smoking:** | never smoked ◯ | currently smoke (some days) ◯ |
| | former smoker ◯ | currently smoke (every day) ◯ |
| **Alcohol:** | never ◯ | heavily ◯ |
| | occasionally ◯ | quit recently ◯ |
| | moderately ◯ | quit a long time ago ◯ |
| **Caffeine:** | none ◯ | tea ◯ |
| | coffee ◯ | carbonated beverages ◯ |
| **Illicit drugs:** | never ◯ | yearly ◯ |
| | socially only ◯ | quit recently ◯ |
| | daily ◯ | quit a long time ago ◯ |
| | weekly ◯ | |
| | monthly ◯ | prefer to discuss with provider ◯ |

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## FAMILY MEDICAL HISTORY

**Please indicate which family members have had these illnesses:**

◯ **Family History Unknown** ◯ **NONE**

| | Father | Mother | Brother | Sister | Son | Daughter | Other |
|---|---|---|---|---|---|---|---|
| Alcohol Abuse | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Anesthetic Complication | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Arthritis | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Bleeding Disorder (such as Anemia) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Breast Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Cervical Cancer | | ◯ | | ◯ | | ◯ | ◯ |
| Colon Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Colon Polyps | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Depression | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Diabetes | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Heart Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| High Blood Pressure | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Kidney Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Lung / Respiratory Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Melanoma | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Migraines | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Ovarian Cancer | | ◯ | | ◯ | | ◯ | ◯ |
| Pancreatic Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Prostate Cancer | ◯ | | ◯ | | ◯ | | ◯ |
| Rectal Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Seizures / Convulsions | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Stroke / CVA of the Brain | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Thyroid Problems | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Other Bowel Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Other Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

◯ Mother, Grandmother, or Sister developed heart disease before the age of 65

◯ Father, Grandfather, or Brother developed heart disease before the age of 55

## SURGICAL HISTORY

**Please mark all surgeries you have had:**

- ◯ **I Have Had No Surgeries**

- ◯ Anal Fissure Repair
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Bypass Surgery for Poor Blood Flow to Legs
- ◯ Dialysis Shunt / Fistula
- ◯ Heller Myotomy
- ◯ Hemorrhoidectomy
- ◯ Liver Surgery
- ◯ Nissen Fundoplication
- ◯ Oral Surgery
- ◯ Pancreas Surgery
- ◯ Sentinel Lymph Node Biopsy
- ◯ Small Bowel Surgery
- ◯ Splenectomy
- ◯ Thyroid Surgery
- ◯ Tonsillectomy
- ◯ Vasectomy

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| | Left | Right | Both | Multiple Times |
|---|---|---|---|---|
| Carotid Artery Surgery | ◯ | ◯ | ◯ | ◯ |
| Laparoscopic Inguinal Hernia Surgery | ◯ | ◯ | ◯ | ◯ |
| Open Inguinal Hernia Surgery | ◯ | ◯ | ◯ | ◯ |
| Ventral / Umbilical Hernia Surgery | ◯ | ◯ | ◯ | ◯ |
| Breast Biopsy | ◯ | ◯ | ◯ | ◯ |
| Breast Cancer Lump Removal | ◯ | ◯ | ◯ | |
| Mastectomy | ◯ | ◯ | ◯ | |
| Breast Augmentation | ◯ | ◯ | ◯ | |
| Breast Reconstruction | ◯ | ◯ | ◯ | |
| Breast Reduction | ◯ | ◯ | ◯ | |
| Cataract Surgery | ◯ | ◯ | ◯ | |
| Foot Surgery | ◯ | ◯ | ◯ | |
| Hip Surgery | ◯ | ◯ | ◯ | |
| Kidney Removal | ◯ | ◯ | ◯ | |
| Knee Surgery | ◯ | ◯ | ◯ | |
| Lung Surgery | ◯ | ◯ | ◯ | |
| Ovary Removal | ◯ | ◯ | ◯ | |
| Shoulder Surgery | ◯ | ◯ | ◯ | |

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| | | |
|---|---|---|
| **Caesarean Section** | ◯ 1 | ◯ >1 |
| **Colon Polyp Removal** | ◯ Open | ◯ Colonoscopy |
| **Colon Removal** | ◯ Partial | ◯ Complete |
| **Gallbladder Surgery** | ◯ Open | ◯ Laparoscopic |
| **Heart** | ◯ Bypass | ◯ Valve |
| **Hysterectomy** (due to cancer) | ◯ Partial | ◯ Complete |
| **Hysterectomy** (not due to cancer) | ◯ Partial | ◯ Complete |
| **Prostate Surgery** | ◯ TURP | ◯ Prostatectomy |
| **Spinal Surgery** | ◯ Neck<br>◯ Mid Back | ◯ Lower Back |
| **Weight Loss Surgery** | ◯ Gastric Bypass<br>◯ Lapband Surgery | ◯ Sleeve Gastrectomy |