

Review of Systems/Medical & Family History Update



Patient Name: _____ Date: _____

Required for questions for insurance compliance

- | | | |
|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Do you have an advance directive? | <input type="checkbox"/> <input type="checkbox"/> Had a flu shot this year? | <input type="checkbox"/> <input type="checkbox"/> Have you or members of your family recently been hospitalized for any reason? |
| <input type="checkbox"/> <input type="checkbox"/> Are you a victim of violence or abuse? | <input type="checkbox"/> <input type="checkbox"/> Had a pneumonia shot? | |

Name of primary care provider (for correspondence): _____

Please indicate below, are you currently experiencing any of these symptoms

Yes		No		General, Constitutional		Yes		No		Musculoskeletal	
					Good general health lately						Joint pain
					Recent weight change						Joint stiffness or swelling
					Fever						Weakness of muscles/joints
					Fatigue						Muscle pain or cramps
Eyes & Vision						Skin & Breasts					
					Eye disease or injury						Rash or itching
					Wear glasses or contact lenses						Change in skin color
					Blurred or double vision						Change in hair or nails
					Glaucoma						Varicose veins
Ears, Nose & Throat						Neurological					
					Hearing loss						Frequent or recurrent headaches
					Ringing in the ears						Light headed or dizzy
					Earaches or drainage						Convulsions or seizures
					Sinus problems						Numbness or tingling sensations
					Nose Bleeds						Tremors
					Mouth sores						Paralysis
					Bleeding gums						Stroke
					Bad breath or bad taste						Head Injury
					Sore throat or voice change						
					Swollen glands in neck						
Heart & Cardiovascular						Psychiatric					
					Heart trouble						Memory loss or confusion
					Chest pain						Nervousness
					Sudden heartbeat changes						Depression
Respiratory						Endocrine					
					Frequent coughing						Glandular or hormone problem
					Spitting blood						Thyroid disease
					Shortness of breath						Diabetes
					Asthma or wheezing						Excessive thirst or urination
Gastrointestinal						Hematologic/Lymphatic					
					Loss of appetite						Slow to heal after cuts
					Change in bowel movements						Easily bruise or bleed
					Nausea or vomiting						Anemia
					Frequent diarrhea						Phlebitis
					Painful bowel movements or constipation						Transfusion
					Blood in stool						Swollen glands
					Stomach pain						
Genitourinary											
					Frequent urination						
					Burning or painful urination						
					Blood in urine						
					Change in force or strain with urination						
					Incontinence or dribbling						
					Kidney stones						
					Sexual difficulty						
					Painful periods						
					Irregular periods						
					Vaginal discharge						
					If you have not had a hysterectomy, please give the date of your last menstrual period: _____						
						<p>_____ Patient or Guardian Signature</p> <p>_____ Physician / PA Signature</p>					