

REVIEW OF SYSTEMS

Name: _____ Date: _____

The following information is geared toward finding any current or past health conditions which may affect or complicate your current condition or its treatment. Do you now have or have you had in the past, symptoms of or treatment for:

Eyes yes no Do you wear glasses or contacts yes no
Ears, Nose, Mouth, or Throat yes no
Gastrointestinal system yes no Do you have indigestion yes no
Pain after eating yes no Stomach cramps yes no
Genitourinary yes no
Have you ever had cancer yes no type: _____

For Men Do you get up and go to the bathroom frequently at night yes no
Have you ever been diagnosed with a prostate condition yes no
If yes enlarged prostate prostate cancer
Did you ever have prostate surgery yes no
If yes, when _____

For Women Do you have painful periods yes no
Do you have anemia yes no
Have you ever had a hysterectomy yes no
If yes, when _____
Did you have any C-Sections yes no
If yes, when _____
Have you been diagnosed with fibrocystic breast disease yes no
Have you ever had breast cancer yes no

Have you had any skin condition requiring treatment yes no
Have you ever had a stroke yes no
Do you have episodes where you feel dizzy yes no
Have you ever been treated for stress yes no
Do you have any hormonal conditions including:
Thyroid yes no Pancreas (diabetes or hypoglycemia) yes no
Any other _____
Do you have any blood conditions or disease yes no
If yes _____
Do you have any lymphatic system conditions or diseases yes no
If yes _____
Is there anything else you feel is important _____
Nearest relative _____ Phone _____

Signature _____

Patient Name: _____

Please indicate beside each activity whether you engage in it:

Often = "O"

Sometimes = "S"

Never = "N"

Social History

- | | |
|---|---|
| <input type="checkbox"/> Horseback riding | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Water Skiing |
| <input type="checkbox"/> Baseball/softball | <input type="checkbox"/> Hunting |
| <input type="checkbox"/> Handball | <input type="checkbox"/> Fishing |
| <input type="checkbox"/> Racquetball | <input type="checkbox"/> Lawn mowing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Weed eater use |
| <input type="checkbox"/> Walking (mile or less) | <input type="checkbox"/> Snow shoveling |
| <input type="checkbox"/> Walking (more than mile) | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Jogging (mile or less) | <input type="checkbox"/> Child care |
| <input type="checkbox"/> Jogging (more than mile) | Age(s) _____ |
| <input type="checkbox"/> Dancing | Weight(s) _____ |
| <input type="checkbox"/> Scuba diving | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Back packing | <input type="checkbox"/> Alcohol ___ per day |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Alcohol ___ per week |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Medication _____ |
| <input type="checkbox"/> Resistance Training | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Free weights | <input type="checkbox"/> Other _____ |

Family History

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes with in the past five years.

- | | |
|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Dependence problems |
| <input type="checkbox"/> Birth of Child | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Drugs |
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Change in job |
| <input type="checkbox"/> Marital separation | <input type="checkbox"/> Loss of job |
| <input type="checkbox"/> Death of a family member or friend | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Handicapped household member | <input type="checkbox"/> Change in living conditions |
| <input type="checkbox"/> Caregiver to family member | <input type="checkbox"/> Change in residence |
| <input type="checkbox"/> Spousal Abuse | <input type="checkbox"/> Change in financial status |