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# REVIEW OF SYSTEM

**NAME** _____ **AGE** _____ **TODAY'S DATE** _____

**EMPLOYER** _____

**DOCTORS** you see now _____

**DOCTORS** you have seen in the past _____

_____

**CURRENT MEDICAL PROBLEMS** _____

_____

_____

**OTHER CONCERNS** you would like to discuss with the doctor _____

_____

**LIST SURGERIES** you have had (include year, surgeon, hospital) _____

_____

_____

_____

**Describe HOSPITALIZATIONS/ ILLNESSES** not included above (include year, hospital) _____

_____

_____

_____

**List PRESCRIPTION MEDICINE** you now take (include dosage, reason you take it, who prescribed it)_____

_____

_____

**List OVER-THE-COUNTER MEDICINES,** vitamins and food supplements you take _____

_____

_____

**DRUG ALLERGIES** _____ **SENSITIVITIES** _____

_____ _____

_____ _____

**SOCIAL HISTORY**

Tobacco Use? NO ☐ YES ☐ How many packs per day? _____ How many years? _____

Did you quit? NO ☐ YES ☐ If so, when? _____

Alcohol NO ☐ YES ☐ Amount per day? _____

Coffee, tea or cola? NO ☐ YES ☐ Amount per day? _____

Do you exercise regularly? NO ☐ YES ☐ How often?_____

What kind of work do you do? _____

Any toxic exposure? NO ☐ YES ☐

What method of contraception do you use (if applicable) _____

–OVER–

**Have you had** (circle):

1.) migraines 2.) hepatitis 3.) mono 4.) ulcer
5.) bleeding problem 6.) blood clots 7.) head injury 8.) drug addiction 9.) gallstones
10.) tuberculosis 11.) STDs 12.) seizures 13.) memory trouble 14.) arthritis
15.) psoriasis 16.) heart murmur 17.) rheumatic fever 18.) polio 19.) shingles
20.) alcoholism 21.) depression 22.) mental illness 23.) gout 24.) hemorrhoids
25.) hearing trouble 26.) vision trouble 27.) other _____

**FEMALE PATIENTS-Do you have any problems with:**

Cramps? NO ☐ YES ☐ Heavy Bleeding NO ☐ YES ☐
Irregular Periods NO ☐ YES ☐ Discharge NO ☐ YES ☐
Painful Intercourse NO ☐ YES ☐ Last Breast Exam/Mammogram _____
Your last Menstrual Period _____ Last Pap Smear _____

**MALE PATIENTS-Do you have any problems with:**

Penile Discomfort? NO ☐ YES ☐ Impotence? NO ☐ YES ☐

Other _____

**Do any of your family members have or have had:**

Cancer NO ☐ YES ☐
Heart attacks NO ☐ YES ☐
High blood pressure NO ☐ YES ☐
Strokes NO ☐ YES ☐
Thyroid disease NO ☐ YES ☐
Diabetes NO ☐ YES ☐
Anemia NO ☐ YES ☐
Kidney disease NO ☐ YES ☐
Ulcers NO ☐ YES ☐
Other _____

| **Family History:** | **Age** | **Illness** |
|---|---|---|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Brothers | _____ | _____ |
| Sisters | _____ | _____ |
| Sons | _____ | _____ |
| Daughters | _____ | _____ |
| Other Relatives | _____ | _____ |

**When was your last:**

1.) tetanus shot _____ 2.) flu shot _____ 3.) EKG _____
4.) TB test _____ 5.) HIV test _____ 6.) sigmoidoscopy _____
7.) chest x-ray _____ 8.) pneumonia shot _____ 9.) hepatitis vaccine _____
10.) rectal exam _____ 11.) blood test _____

**Anything else?** _____

_____

_____

_____

Please Sign and Date: _____