Review of Systems/Medical and Family History Update

Patient Name: _____ Date: _____

Required questions for insurance compliance

Do you have an advance directive? ..... no yes
Are you a victim of violence or abuse? ..... no yes
Had a flu shot this year? ..... no yes
Had a pneumonia shot? ..... no yes

NAME OF PRIMARY CARE PROVIDER (for correspondence): _____

HAVE YOU OR MEMBERS OF YOUR FAMILY RECENTLY BEEN HOSPITALIZED FOR ANY REASON? NO YES

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Good general health lately ..... no yes
Recent weight change ..... no yes
Fever ..... no yes
Fatigue ..... no yes

Eyes and vision

Eye disease or injury ..... no yes
Wear glasses or contact lenses ..... no yes
Blurred or double vision ..... no yes
Glaucoma ..... no yes

Ears, nose, throat

Hearing loss ..... no yes
Ringing in the ears ..... no yes
Earaches or drainage ..... no yes
Sinus problems ..... no yes
Nose bleeds ..... no yes
Mouth sores ..... no yes
Bleeding gums ..... no yes
Bad breath or bad taste ..... no yes
Sore throat or voice change ..... no yes
Swollen glands in neck ..... no yes

Heart and Cardiovascular

Heart trouble ..... no yes
Chest pains ..... no yes
Sudden heartbeat changes ..... no yes
Swelling of feet, ankles, hands ..... no yes

Respiratory

Frequent coughing ..... no yes
Spitting up blood ..... no yes
Shortness of breath ..... no yes
Asthma or wheezing ..... no yes

Gastrointestinal

Loss of appetite ..... no yes
Change in bowel movements ..... no yes
Nausea or vomiting ..... no yes
Frequent diarrhea ..... no yes
Painful bowel movements or constipation ..... no yes
Blood in stool ..... no yes
Stomach pain ..... no yes

Genitourinary

Frequent urination ..... no yes
Burning or painful urination ..... no yes
Blood in urine ..... no yes
Change in force or strain with urination ..... no yes
Incontinence or dribbling ..... no yes
Kidney stones ..... no yes
Sexual difficulty ..... no yes
Painful periods ..... no yes
Irregular periods ..... no yes
Vaginal discharge ..... no yes

Musculoskeletal

Joint pain ..... no yes
Joint stiffness or swelling ..... no yes
Weakness of muscles/joints ..... no yes
Muscle pain or cramps ..... no yes
Back pain ..... no yes
Cold extremities ..... no yes
Difficulty in walking ..... no yes

Skin and breasts

Rash or itching ..... no yes
Change in skin color ..... no yes
Change in hair or nails ..... no yes
Varicose veins ..... no yes
Breast pain ..... no yes
Breast lump ..... no yes
Breast discharge ..... no yes

Neurological

Frequent or recurrent headaches ..... no yes
Light headed or dizzy ..... no yes
Convulsions or seizures ..... no yes
Numbness or tingling sensations ..... no yes
Tremors ..... no yes
Paralysis ..... no yes
Stroke ..... no yes
Head injury ..... no yes

Psychiatric

Memory loss or confusion ..... no yes
Nervousness ..... no yes
Depression ..... no yes
Sleep problems ..... no yes

Endocrine

Glandular or hormone problem ..... no yes
Thyroid disease ..... no yes
Diabetes ..... no yes
Excessive thirst or urination ..... no yes
Heat or cold intolerance ..... no yes
Dry skin ..... no yes
Change in hat or glove size ..... no yes

Hematologic/Lymphatic

Slow to heal after cuts ..... no yes
Easily bruise or bleed ..... no yes
Anemia ..... no yes
Phlebitis ..... no yes
Transfusion ..... no yes
Swollen glands ..... no yes

If you have not had a hysterectomy, please give the date of your last menstrual period _____

Patient sign here: _____

Physician/PA sign here: _____