

REVIEW OF SYSTEMS

Patient Name: _____

MEDICAL HISTORY

What medical problems do you have? _____

What operations have you had and when? _____

What medications are you taking? _____

Have you or a family member ever had a reaction to anesthesia? ___ Yes ___ No Please Explain: _____

___ Stomache-ache while taking anti-inflammatories (includes Aleve/Advil) What anti-inflammatories have you already had a problem with?

Do you have a Latex Allergy? ___ Yes ___ NO

ALLERGIC TO ANY MEDICATIONS? ___ YES ___ NO If YES list & describe reaction: _____

Have you had any of these symptoms? If no, check NONE.

- 1) GI ___ Heartburn, Ulcers ___ Nausea, vomiting ___ Blood in Stool ___ Hepatitis ___ Liver Disease ___ None ___ Year
- 2) ENDO ___ Thyroid Disease ___ Heat or Cold Intolerance
- 3) CON ___ Weight Loss ___ Loss Of Appetite _____ None ___ Year
- 4) EYE ___ Blurred Vision ___ Double Vision ___ Vision Loss
- 5) ENT ___ Hearing Loss ___ Hoarseness ___ Trouble swallowing _____ None ___ Year
- 6) CV ___ Chest Pain ___ Palpitations
- 7) RS ___ Chronic Cough ___ Shortness of Breath
- 8) GU ___ Painful Urination ___ Blood in Urine ___ Kidney Problems
- 9) SK ___ Frequent Rashes ___ Skin Ulcers ___ Lumps ___ Psoriasis
- 10) NEU ___ Headaches ___ Dizziness ___ Seizures
- 11) PSY ___ Depression ___ Drug/Alcohol Addiction ___ Sleep disorder
- 12) HEM ___ Easy Bleeding ___ Easy Bruising ___ Anemia
- 13) ARE YOU HIV POSITIVE: ___ NO ___ YES

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

___ Diabetes _____ / ___ High Blood Pressure / ___ Rheumatoid Arthritis _____ / ___ None

Do any direct relatives have the same condition you are being seen for today? ___ Yes ___ No

SOCIAL HISTORY:

Please check off the answer that applies.

Do you use tobacco? ___ No ___ Yes If Yes, packs per day _____ Patient informed of Smoking Risk? ___ Yes

Alcohol use? ___ No ___ Yes If Yes, how often? ___ Daily ___ Other _____/week

Marital History: ___ M ___ S ___ D ___ W How many people live with you? _____

Occupation: _____ Student

Employer: _____

Do you plan to be working 6 months from now? ___ Yes ___ No

SIGNATURE: _____ **DATE:** _____

Completed _____ Date: _____

Review #1 by _____ MD Date: _____ Review #2 by _____ MD Date: _____