PLEASE FILL IN BUBBLE IF "YES" REVIEW OF SYSTEMS and SOCIAL HISTORY

GENERAL

Fatigue	O Yes
Weakness	O Yes
Fever	O Yes
Chills	O Yes
Weight Gain	O Yes
Weight Loss	O Yes
Difficulty sleeping	O Yes
Excessive thirst	O Yes
Bleeding tendency	O Yes
Night Sweats	O Yes

EAR / NOSE / THROAT

Ringing in Ears	O Yes
Hearing Loss	O Yes
Hearing aids	O Yes
Nose Bleed	O Yes
Nasal congestion	O Yes
Sinus trouble	O Yes
Post-nasal Drip	O Yes
Nasal discharge	O Yes
Dentures	O Yes
Sore mouth	O Yes
Bleeding gums	O Yes
Frequent sore throats	O Yes
Hoarseness	O Yes
Hayfever	O Yes
Allergies	O Yes

CARDIOLOGY

Racing heart rate	O Yes
Fluttering	O Yes
Skipped beat	O Yes
Chest Pain	O Yes
Swollen feet or legs	O Yes

RESPIRATORY

Persistent Cough	O Yes
Difficulty breathing	O Yes
Wheezing	O Yes
Sitting up to breathe	O Yes
Sleep with more than one pillow	O Yes

GASTROENTEROLOGY

Poor appetite	O Yes
Difficulty swallowing	O Yes
Indigestion	O Yes
Heartburn	O Yes
Acid reflux	O Yes
Nausea	O Yes
Vomiting	O Yes
Abdominal Pain	O Yes
Change in Bowel Habits	O Yes
Diarrhea	O Yes
Constipation	O Yes
Black stools	O Yes
Rectal bleeding	O Yes
Hemorrhoids	O Yes

MUSCULOSKELETAL

Joint Pain	O Yes
Joint Swelling	O Yes
Joint Stiffness	O Yes
Neck pain	O Yes
Neck Stiffness	O Yes
Back Pain	O Yes
Muscle Aches	O Yes
Muscle weakness	O Yes
Falls	O Yes

DERMATOLOGY

Change in mole	O Yes
Bruising	O Yes
Sores	O Yes
Rash	O Yes

UROLOGY

Pain with urination	O Yes
Burning with urination	O Yes
Urinary Frequency	O Yes
Excessive urination at night	O Yes
Excessive urination during day	O Yes
Slow urinary stream	O Yes
Loss of urine with cough or sneeze	O Yes

NEUROLOGY

Confusion	O Yes
Memory Loss	O Yes
Numbness	O Yes
Weakness	O Yes
Loss of coordination	O Yes
Dizziness	O Yes

OPTHALMOLOGY

Glasses	O Yes
Contacts	O Yes
Change in Vision	O Yes
Blurred Vision	O Yes
Eye pain	O Yes
Spots in vision	O Yes
Eye exam last year	O Yes

NAME_____ DATE _____ PAGE 1

Cont'd REVIEW of SYSTEMS and SOCIAL HISTORY
PLEASE FILL IN BUBBLE IF "YES"

FEMALE REPRODUCTIVE

Are you still having periods O Yes
Heavy periods O Yes
Irregular periods O Yes
If no periods date stopped_____
Menopause (Age_____) O Yes
Hot Flashes O Yes
Night sweats O Yes
Breast Implants O Yes
Abnormal Mammo (date_____) O Yes
Breast lump O Yes
Breast Biopsy (date_____) O Yes
Abnormal PAP (date_____) O Yes
Hysterectomy O Yes
Ovaries removed O Yes
Uterus removed O Yes
Pain with intercourse O Yes
Pregnancies #_____ O Yes
Deliveries #_____ O Yes
C-sec #_____ O Yes
Miscarriage #_____ O Yes
Abortion #_____ O Yes

MALE REPRODUCTIVE

Hernia O Yes
Difficulty urinating O Yes
Prostate problems O Yes
Testicular pain O Yes
Difficulty with Erection O Yes

CONTRACEPTION METHOD

Birth control pills O Yes
Patch O Yes
IUD O Yes
Diaphram O Yes
Vaginal ring O Yes
Tubal ligation O Yes
Condom O Yes
Vasectomy O Yes
other O Yes
specify type _____

PSYCHOLOGY

Depression O Yes
Sadness O Yes
Withdrawn or flat mood O Yes
Cry often O Yes
Irritable O Yes
Anxiety O Yes
Easily upset O Yes
Poor concentration O Yes
Under significant stress O Yes
Loss of interest in pleasurable activities O Yes
Thoughts of hurting self or others O Yes

Have you ever been in a relationship
feeling: threatened, hurt or afraid? O Yes
Feeling socially isolated O Yes
Is there violent conflict in your home O Yes

MARITAL STATUS

Married O Yes
Single O Yes
Divorced O Yes
Widowed O Yes
Domestic Partner O Yes

SOCIAL HISTORY

Do you smoke O Yes
Have you ever smoked O Yes
Packs per day_____
Years smoking_____
Do you chew tobacco O Yes
Do you drink alcohol O Yes

Drinks per week _____
Recreational drug use O Yes
Use seat belts O Yes
Routine dental care O Yes
Exercise regularly O Yes
Exercise _____x/week
Follow diet O Yes
low in fat O Yes
low in salt O Yes
low cholesterol O Yes

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