PATIENT NAME:_____ DATE:_____

REVIEW OF SYSTEMS:

Do you presently have any of the following: (Please check YES or NO)

	YES	NO
Change in vision.	___	___
Hoarseness.	___	___
Change in swallowing. . . .	___	___
Weight Loss (recent). . . .	___	___
Rashes.	___	___

CARDIOVASCULAR-RESPIRATORY:	YES	NO
Chronic cough	___	___
Chest pain.	___	___
Palpitations.	___	___
Shortness of breath	___	___
Coughing up blood	___	___

GENITOURINARY:	YES	NO
History bladder infection	___	___
Pain on urination	___	___
Difficulty controlling urination	___	___

HEMATOLOGIC/LYMPHATIC:	YES	NO
Bleeding Problems	___	___
Frequent nose bleeds. . . .	___	___
Easy bruising	___	___

GASTROINTESTINAL:	YES	NO
Change in bowel habits. . .	___	___
Abdominal Pain.	___	___
Nausea or vomiting.	___	___

NEUROLOGICAL/PSYCHIATRIC:	YES	NO
Headaches	___	___
Seizures.	___	___
Numbness.	___	___
Site of numbness _____		
Weakness.	___	___
Site of weakness_____		
Depression.	___	___
Anxiety	___	___

FAMILY HISTORY:	YES	NO
Diabetes.	___	___
Rheumatoid Arthritis. . . .	___	___
Gout.	___	___
Muscle/Nerve Disorder . . .	___	___

___ All other systems negative

Do you presently take Medications?
YES___ NO___ If yes, what medication do you take?_____
_____
_____
_____

	YES	NO
ALLERGIES TO MEDICATION:. .	___	___

If yes, what medications are you allergic to?_____
_____
_____

HEIGHT_____

WEIGHT_____

OCCUPATION_____

SOCIAL HISTORY:	YES	NO
Do you smoke?	___	___
# of packs per day. . . .	___	___
Duration of smoking history_____		
Do you drink liquor?. . . .	___	___
# of drinks per day	___	___

PAST MEDICAL HISTORY:	YES	NO
Heart Attack.	___	___
High Blood Pressure	___	___
Asthma.	___	___
Diabetes.	___	___
Thyroid Disease	___	___
Cancer.	___	___
Type_____		
Ulcers.	___	___
Phlebitis/blood clots . . .	___	___
Kidney Disease.	___	___
Liver Disease/Hepatitis . .	___	___
Stroke.	___	___

Other_____
_____
_____

Prior Surgeries - *please list*
_____
_____
_____
_____

_____
PHYSICIAN SIGNATURE