



Name: _____
(Please Print Clearly)

Date: _____ MR #: _____

New Patient - Review of Systems

Have you, in the last three to six months, had any of the following? Check all that apply.

Constitutional:

- Fatigue
- Weakness
- Fever
- Night sweats
- Chills
- Weight change
- Change in appetite

Allergy/Immunologic:

- New allergies

HEENT:

- Blurred vision
- Nose bleeds
- Difficulty swallowing
- Hearing problems
- Headaches
- Mouth sores

Endocrine:

- Increased thirst
- Thyroid problems
- Hot flashes

Respiratory:

- Cough
- Shortness of breath
- Coughing blood
- Wheezing
- Difficulty breathing when lying down

Breast:

- Pain or lump in breasts
- Skin changes
- Nipple discharge

Cardiovascular:

- Chest pain
- Swelling
- Palpitations (heart racing)
- Sweating with chest pain
- Dizziness

Gastrointestinal:

- Abdominal pain/bloating
- Trouble swallowing
- Nausea/vomiting
- Constipation
- Diarrhea
- Heartburn
- Vomiting blood
- Red blood with bowel movements
- Black tarry stools

Genitourinary:

- Burning on urination
- Blood in urine
- Incontinence
- Change in color of urine
- Change in sexual function
- Vaginal bleeding or spotting

Musculoskeletal:

- Muscle weakness

Skin:

- Changes in skin color
- Easy bruising
- Nail changes
- Hair loss
- Rash
- New lumps or bumps

Neurological/Psychiatric:

- Seizures
- Depression/Anxiety
- Fainting
- Numbness/Tingling
- Mood changes
- Change in strength
- Headaches
- Sleeping problems

Pain: Location: _____

Rate the pain from 0 to 10: _____

(Over for more questions)



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New Patient - Past Medical History

PRIMARY CARE PHYSICIAN: _____

PHARMACY: _____ Location: _____

Pharmacy Phone: _____ Fax: _____

PAST MEDICAL HISTORY (other than present illness):

PAST SURGERIES/SERIOUS ACCIDENTS:

TRAUMA:

CURRENT MEDICATIONS: _____

ALLERGIES: _____

PAST TRANSFUSIONS: YES NO (Circle One)

FAMILY MEDICAL HISTORY:

Mother: _____

Father: _____

Siblings: _____

Family history of cancer or blood diseases: _____

WOMEN ONLY: Age Menses began: _____ Age Menopause began: _____

Reason for menopause: Surgical _____ Natural _____

SOCIAL HISTORY:

Marital Status: _____

Children: _____

Alcohol/Drug Use: _____ Tobacco Use: _____

Occupation: _____

WHAT IS YOUR MAIN CONCERN REGARDING YOUR DIAGNOSIS AND YOUR VISIT TO OUR OFFICE?

(Over for more questions)