REVIEW OF SYMPTOMS (Confidential)

Name:		Social Security Number:	Today's Date:
Street Address:	City:	State:	Zip:
Home Phone Number:	Birthdate:	Date of last physical examination:	

What is your reason for visit? Is this a work related injury? _____Yes _____No If yes what is date of injury? _____

SYMPTOMS Check symptoms you have or have had in the past

BREAST
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Skin change

Date of last mammogram: _____

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ History of MI
- ☐ MVP
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Bypass Surgery or Stents
- ☐ Heart valve surgery

EAR/NOSE/THROAT
- ☐ Difficulty swallowing
- ☐ Hoarseness

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disorder

EYES
- ☐ Yellow
- ☐ Visual changes

GASTROINTESTINAL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Hepatitis

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Loss of weight
- ☐ Sweats

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Testicle mass
- ☐ Kidney disease
- ☐ Prostate problems

HEME/LYMPH
- ☐ History of bleeding
- ☐ Taking blood thinners (including Aspirin)
- ☐ Anemia
- ☐ Swollen lymph nodes
- ☐ AIDS

MUSCLE/JOINT/BONE

Pain in:
- ☐ Joints
- ☐ Muscle

NEURO
- ☐ Stroke
- ☐ TIA

PSYCH
- ☐ Past treatment
- ☐ Psych meds

RESPIRATORY
- ☐ Emphysema
- ☐ History of asthma

SKIN
- ☐ Bruise easily
- ☐ Change in moles

ARE YOU BEING TREATED FOR SLEEP APNEA? ____ Yes ____ No

HISTORY OF BLOOD CLOTS? ____YES ____ No

HISTORY OF STAPH (MRSA) INFECTIONS? ____YES ____ No

ARE YOU ALLERGIC TO LATEX? ____YES ____ No

MEDICATIONS List medications and dosages you are currently taking

MEDICATIONS AND DOSE	MEDICATIONS AND DOSE

ALLERGIES

(If no drug allergies check box below; if you have allergies list meds below)

☐ No Known Drug Allergies

If you have drug allergies please list them below:

FAMILY HISTORY Fill in health information about your family

☐ Single ☐ Married ☐ Divorced

Number of Children _____ Ages: _____

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers or Sisters				

Check if, your blood relatives had any of the following:

	Relationship to you
☐ Cancer	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	

HEALTH HABITS

Check which substances you use and describe how much you use

☐	Caffeine	
☐	Tobacco	
☐	Drugs	

SERIOUS ILLNESS/INJURIES

DATE	OUTCOME

YOUR OCCUPATION

PAST SURGERIES/HOSPITALIZATIONS

Year	Hospital/Surgery	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ____ Yes _____ No

If yes, please give approximate dates _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

_____ _____
Patient Signature Date

_____ _____
Reviewed By Signature Date

(Revised 8/13/07)