

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes what is date of injury? _____	

SYMPTOMS Check symptoms you have or have had in the past

BREAST <input type="checkbox"/> Breast lump <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Skin change Date of last mammogram: _____	ENDOCRINE <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder EYES <input type="checkbox"/> Yellow <input type="checkbox"/> Visual changes	GENITO-URINARY <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Testicle mass <input type="checkbox"/> Kidney disease <input type="checkbox"/> Prostate problems	NEURO <input type="checkbox"/> Stroke <input type="checkbox"/> TIA PSYCH <input type="checkbox"/> Past treatment <input type="checkbox"/> Psych meds
CARDIOVASCULAR <input type="checkbox"/> High blood pressure <input type="checkbox"/> History of MI <input type="checkbox"/> MVP <input type="checkbox"/> Pacemaker <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Bypass Surgery or Stents <input type="checkbox"/> Heart valve surgery	GASTROINTESTINAL <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hepatitis	HEME/LYMPH <input type="checkbox"/> History of bleeding <input type="checkbox"/> Taking blood thinners (including Aspirin) <input type="checkbox"/> Anemia <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> AIDS	RESPIRATORY <input type="checkbox"/> Emphysema <input type="checkbox"/> History of asthma SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Change in moles
EAR/NOSE/THROAT <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness	GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Loss of weight <input type="checkbox"/> Sweats	MUSCLE/JOINT/BONE Pain in: <input type="checkbox"/> Joints <input type="checkbox"/> Muscle	ARE YOU BEING TREATED FOR SLEEP APNEA? <input type="checkbox"/> Yes <input type="checkbox"/> No HISTORY OF BLOOD CLOTS? <input type="checkbox"/> YES <input type="checkbox"/> No HISTORY OF STAPH (MRSA) INFECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> No ARE YOU ALLERGIC TO LATEX? <input type="checkbox"/> YES <input type="checkbox"/> No

MEDICATIONS List medications and dosages you are currently taking	ALLERGIES
MEDICATIONS AND DOSE	(If no drug allergies check box below; if you have allergies list meds below)
	<input type="checkbox"/> 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	Check if, your blood relatives had any of the following:	Relationship to you
Father					<input type="checkbox"/> Cancer	
Mother					<input type="checkbox"/> Diabetes	
Brothers or Sisters					<input type="checkbox"/> Heart Disease, Strokes	
					<input type="checkbox"/> High Blood Pressure	

HEALTH HABITS Check which substances you use and describe how much you use	SERIOUS ILLNESS/INJURIES	YOUR OCCUPATION
	DATE OUTCOME	
Caffeine		
Tobacco		
Drugs		

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