

Review of Systems

Check here if no change since your last visit to this office.

Have you ever had problems with your:

	Circle	Describe all yes responses
Eyes	Yes No	_____
Ears, nose, throat	Yes No	_____
Digestive problem	Yes No	_____
Bladder or prostate problem	Yes No	_____
Diabetes	Yes No	_____
High blood pressure	Yes No	_____
Heart disease	Yes No	_____
High cholesterol	Yes No	_____
Kidney disease	Yes No	_____
Bleeding problems	Yes No	_____
Hepatitis or liver disease	Yes No	_____
Depression	Yes No	_____
Cancer	Yes No	_____
Arthritis	Yes No	_____
Lungs or breathing problems	Yes No	_____
Seizures or neurologic disease	Yes No	_____

Family History

Check here if no change since your last visit to this office.

Significant family history:

Social History

Check here if no change since your last visit to this office.

Employed (occupation: _____) Student Retired

Single Married Divorced Widowed

Children? No Yes# _____

Exercise? Daily Weekly Rarely

What type of exercise? _____

History of substance abuse? No Yes What type? _____

Smoke currently? No Yes If yes, _____ packs per day for _____ years.

Quit smoking? No This year > 5 years > 10 years

Alcohol consumption? Never Daily 1-2 times per week Rarely

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____