



List Current Medications:

Name	dose	how often you take

List Past Surgeries: Include dates if known

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List Known Drug Allergies:

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List previous hospitalizations: (Other than childbirth or surgeries)

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**Review of Systems (ROS): These are current problems only.**  
Check current problems you have

Constitutional

- Fatigue
- Weight loss
- Weight gain
- Night Sweats
- Loss of appetite
- Fevers

Eyes:

- Visual disturbances
- I currently wear glasses/contacts
- Cataracts
- Red eye
- Double vision
- Difficulty seeing
- Eye injury or pain

Ears, Nose, Throat

- Loss of hearing
- Ear or nasal discharge
- Loss of smell
- Sore throat
- Hoarseness
- Ringing in the ears
- Itching or persistent runny nose

Cardiovascular

- Chest pains
- Shortness of breath
- Heart palpitations
- Leg swelling

Respiratory

- Persistent cough
- Wheezing
- Coughing up blood
- Night sweats
- Sleep Apnea

Gastrointestinal

- Abdominal Pain
- Nausea
- Vomiting
- Pain with swallowing
- Food sticking
- Spitting up blood
- Heartburn
- Constipation
- Diarrhea
- Blood in stool
- Black stools

Genital urinary

- Urinary frequency
- Urgency
- Pain with urination
- Incontinence
- Blood in urine

Muscular skeletal

- Pain
- Focal weakness
- Muscle cramps
- Significant loss of strength
- Restricted joint motion
- Joint swelling
- Joint pains
- Joint deformities
- Back pains

Skin/Breasts

- Rashes
- Bruising
- Persistent itching
- Unstable moles
- Breast tenderness
- Nipple discharge
- Breast lumps / masses

Neurological

- Numbness / tingling
- Loss of sensation
- Focal weakness
- Unusual difficulty with concentration / memory
- Gait disturbance
- Seizures
- Tremors
- Speech disturbances
- Balance problems
- Dizziness
- Headaches

Psychiatric

- Sleep disturbances
- Eating disturbances
- Major depression
- Suicidal ideations / attempts
- Phobias
- Panic attacks

Endocrinology

- Cold/ heat intolerance
- Frequency of urination, drinking or eating
- Trouble with wound healing

Hematology/Lymph nodes

- Bleeding
- Easy bruising
- Recurring infections
- Lymph node swelling

Male history

- Testicular pain
- Testicular enlargement
- Testicular atrophy
- Hernias
- Urinary hesitancy
- Frequent urinating at night
- Weak urinary stream
- Dribbling
- Incomplete voiding
- Penile discharge

Female History:

Number of pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_  
Adoptions \_\_\_\_\_

- \_\_\_\_\_ Painful periods
- \_\_\_\_\_ Irregular periods/bleeding
- \_\_\_\_\_ Heavy periods
- \_\_\_\_\_ Birth control usage
- \_\_\_\_\_ Menopause
- \_\_\_\_\_ Difficulty with conception
- \_\_\_\_\_ Difficulty with childbirth
- \_\_\_\_\_ Vaginal Discharge
- \_\_\_\_\_ Pelvic mass
- \_\_\_\_\_ Recurrent/Persistent pelvic pain
- \_\_\_\_\_ Painful intercourse

**Social History (circle correct answer and fill in blanks)**

Smoking history: Currently Smoke: Yes \_\_\_\_\_ No \_\_\_\_\_

How much do you smoke? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

Have you ever smoked in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how much did you smoke and when did you quit? \_\_\_\_\_

Chewing Tobacco: Yes \_\_\_\_\_ No \_\_\_\_\_

Alcohol Consumption: Yes \_\_\_\_\_ No \_\_\_\_\_  
Rate drinking amount; Rare Social Heavy

How many drinks per day? \_\_\_\_\_

Illicit/ Illegal drug usage: Yes \_\_\_\_\_ No \_\_\_\_\_  
Current Drugs Used: \_\_\_\_\_

Past drugs Used: \_\_\_\_\_

Marital Status: Married widowed single divorced

Children: Yes No How many \_\_\_\_\_

Occupation: \_\_\_\_\_

Educational Level: \_\_\_\_\_

Exercise Habits: \_\_\_\_\_

**Family History (circle answer and fill in applicable blanks)**

For each listed below please indicate age, living or deceased, current medical conditions and / or cause of death

Father: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Mother age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased comments:\_\_\_\_\_

Do any other family members have a history of any of the following diseases or conditions?

Diabetes                      Hypertension                      Cancer                      Heart Disease

High cholesterol    Other:\_\_\_\_\_

If so, please indicate who. \_\_\_\_\_