



List Current Medications: (Include Medications, Vitamins, Herbs, and Supplements)

Name	dose	how often you take	reason for taking

List Known Drug Allergies:

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

Constitutional

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

Eyes:

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

Ears, Nose, Throat

- Loss of hearing
- Loss of smell
- Sore throat
- Hoarseness
- Ringing in the ears

Cardiovascular

- Chest pains
- Shortness of breath
- Heart palpitations-(skipping, missed, or irregular beats)
- Leg swelling

Respiratory

- Persistent cough
- Wheezing

- Coughing up blood
- Snoring

#### Gastrointestinal

- Abdominal Pain
- 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
- Losing control of urine
- Blood in urine

#### Muscular skeletal

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

#### Skin/Breasts

- Rashes
- Persistent itching
- Moles which are changing
- History of significant sun exposure
- Breast tenderness
- Nipple discharge
- Breast lumps / masses

#### Neurological

- Numbness / tingling
- Focal weakness
- Unusual difficulty with concentration / memory
- Walking difficulty
- Seizures
- Tremors
- Speech disturbances
- Balance problems
- Dizziness
- Headaches
- Excessive daytime sleepiness

Psychiatric

- Sleep disturbances
- Eating disturbances
- Depression
- Anxiety
- Suicidal ideations / attempts
- Phobias
- Panic attacks

Endocrinology

- Cold/ heat intolerance
- Frequency of urination, drinking or eating

Hematology/Lymph nodes

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

Male history

- Testicular pain
- Testicular enlargement or 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
- Vaginal Discharge
- 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

How many drinks on average per day/week \_\_\_\_\_

How many drinks per setting \_\_\_\_\_

1 drink = 12oz beer, 4oz wine, 1.5oz liquor

Illicit/ Illegal drug usage: Yes No

Current Drugs Used: \_\_\_\_\_

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

Marital Status: Married widowed single divorced separated

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

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

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

Dairy / Milk intake: \_\_\_\_\_

Daily Caffeine intake: (coffee, tea, soda, chocolate, and energy drinks): \_\_\_\_\_

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

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

Father: living/deceased at age \_\_\_\_ medical conditions: \_\_\_\_\_

\_\_\_\_\_

Mother: living/deceased at age \_\_\_\_ medical conditions: \_\_\_\_\_

\_\_\_\_\_

Brother: living/deceased Medical conditions: \_\_\_\_\_

Brother: living/deceased Medical conditions: \_\_\_\_\_

Brother: living/deceased Medical conditions: \_\_\_\_\_

Brother: living/deceased Medical conditions: \_\_\_\_\_

Brother: living/deceased Medical conditions: \_\_\_\_\_

Sister: living/deceased Medical conditions: \_\_\_\_\_

Sister: living/deceased Medical conditions: \_\_\_\_\_

Sister: living/deceased Medical conditions: \_\_\_\_\_

Sister: living/deceased Medical conditions: \_\_\_\_\_

Sister: living/deceased Medical conditions: \_\_\_\_\_

Maternal Grandfather: living/ deceased Medical conditions: \_\_\_\_\_

Maternal Grandmother: living/ deceased Medical conditions: \_\_\_\_\_

Paternal Grandfather: living/ deceased Medical conditions: \_\_\_\_\_

Paternal Grandmother: living/ deceased Medical conditions: \_\_\_\_\_

Any other family members with the following diseases or condition?

Diabetes, High Blood Pressure, Cancer, Heart Disease, Stroke, DVTs

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