



**List Past Surgeries: Include dates if known**

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**List previous hospitalizations: (Other than 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:

- Prior eye exams done by an optometrist or ophthalmologist
- Squinting (has to sit next to the TV to see)
- Difficulty seeing things up close
- "Crossed eyes"
- Red eye
- Eye injury or pain

Ears, Nose, Throat

- Problems with ear infections
- Loss of hearing or decreased hearing
- Frequent runny nose
- Bad breath
- Sore throat
- Problems with teeth or gums
- Itching or persistent runny nose
- Speech problems

#### Cardiovascular

- History of heart murmur
- Congenital heart problems
- Chest pains
- Shortness of breath or tires easily with exertion
- Heart palpitations
- Fainting spells

#### Respiratory

- Persistent cough
- Wheezing episodes
- Snoring or mouth breathing

#### Gastrointestinal

- Abdominal Pain
- Nausea
- Vomiting
- Feeding problems
- Heartburn or acid taste in mouth
- Constipation
- Diarrhea
- Blood in stool

#### Genito-urinary

- Urinary frequency
- Pain with urination
- Bedwetting
- Blood in urine

#### Female gynecological

- Age of onset of menses
- Approximate length of cycles (from start date to start date)
- Irregular cycles
- Heavy menstrual bleeding
- Bad menstrual cramps
- Vaginal discharge

#### Male genito-urinary

- Testicular masses or enlargement
- History of undescended testicle
- Penile or testicular pain
- Penile discharge

#### Muscular skeletal

- Pain in muscles or bones
- Weakness in arms or legs
- Joint swelling
- Joint deformities

\_\_\_\_\_ Back pains

#### Skin

- \_\_\_\_\_ Dry skin
- \_\_\_\_\_ Rashes
- \_\_\_\_\_ Bruising
- \_\_\_\_\_ Persistent itching
- \_\_\_\_\_ Unstable moles

#### Breasts

- \_\_\_\_\_ Breast tenderness
- \_\_\_\_\_ Nipple discharge
- \_\_\_\_\_ Breast lumps / masses

#### Neurological

- \_\_\_\_\_ Numbness / tingling
- \_\_\_\_\_ Problems with walking
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Tremors
- \_\_\_\_\_ Speech problems
- \_\_\_\_\_ Balance problems
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Headaches

#### Psychiatric

- \_\_\_\_\_ Sleep disturbances
- \_\_\_\_\_ Eating disturbances
- \_\_\_\_\_ Major depression
- \_\_\_\_\_ Suicidal ideations / attempts
- \_\_\_\_\_ Any particular fears
- \_\_\_\_\_ Panic attacks or anxiety
- \_\_\_\_\_ Attention problems
- \_\_\_\_\_ Hyperactivity problems

#### Endocrinology

- \_\_\_\_\_ Cold/ heat intolerance
- \_\_\_\_\_ Frequency of urination
- \_\_\_\_\_ Excessive thirst

#### Hematology/Lymph nodes

- \_\_\_\_\_ Excessive bleeding when cut or bleeding from nose or gums
- \_\_\_\_\_ Easy bruising
- \_\_\_\_\_ Lymph node swelling

#### Allergy:

- \_\_\_\_\_ history of seasonal allergies
- \_\_\_\_\_ any allergies to pets
- \_\_\_\_\_ frequent runny nose
- \_\_\_\_\_ frequent throat clearing
- \_\_\_\_\_ frequent itchy or watery eyes

**Social history:**

Who lives at home? (Names and ages of parents/step-parents, siblings)

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Does your child attend daycare in a home or daycare setting? \_\_\_\_\_

Name of school and grade level \_\_\_\_\_

Any concerns about school performance? \_\_\_\_\_

Any concerns about social interactions with friends? \_\_\_\_\_

What type of sports/activities/hobbies does your child participate in?

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Any smokers in the home? \_\_\_\_\_

Any pets in the home? \_\_\_\_\_

**For children 12 years of age and older, please complete the following:**

Any concerns with alcohol consumption: Yes            No

Any concerns with Illicit/ Illegal drug usage: Yes    No

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

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

Any concerns with cigarette smoking or chewing tobacco use?    Yes            No

History of sexual activity?            Yes            No

Any prior pregnancies?            Yes            No

Any history of STD's?            Yes            No

**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  
medical problems:\_\_\_\_\_

Mother age\_\_\_\_\_ living/deceased  
Medical problems:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased  
medical problems:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased  
Medical problems:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased  
medical problems:\_\_\_\_\_

Brother: age\_\_\_\_\_ living/deceased  
Medical problems:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased  
Medical problems:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased  
medical problems:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased  
Medical problems:\_\_\_\_\_

Sister: age\_\_\_\_\_ living/deceased  
medical problems:\_\_\_\_\_

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. \_\_\_\_\_