DOCTORS MED CARE

Review of Systems

Health History:

Check(√) any symptoms you currently have or have had in the past year

General
__Chills
__Depression/Nervousness
__Dizziness/Fainting
__Fever
__Forgetfulness
__Headache
__Loss of Sleep
__Loss of Weight
__Numbness
__Sweats

Muscle/Joint/Bone
__Arms __Hips
__Back __Legs
__Feet __Hand
__Hands __Shoulders

Genito-Urinary
__Blood in Urine
__Frequent Urination
__Lack of Bladder Control
__Painful Urination

Gastrointestinal
__Appetite Poor
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting
__Vomiting Blood

Cardiovascular
__Chest Pain
__High/Low Blood Pressure
__Irregular/Rapid Heart Rate
__Poor Circulation
__Swelling of Ankles
__Varicose Veins

Eye, Ear, Nose, Throat
__Bleeding Gums
__Blurred Vision
__Crossed Eyes
__Difficulty Swallowing
__Double Vision
__Earache/Ear Discharge
__Hay Fever
__Hoarseness
__Loss of Hearing
__Nosebleeds
__Persistent Cough
__Ringing in Ears
__Sinus Problems
__Vision-Flashes/Halos

Skin
__Bruise Easily
__Hives
__Itching/Rash
__Change in Moles
__Scars
__Sore That Won't Heal

Men ONLY
__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis
__Other_____

Women ONLY
__Abnormal Pap Smear
__Bleeding Between Periods
__Breast Lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge
__Other_____
Date of Last Period:_____
Date of Last Pap Smear:_____
Have you had a mammogram: Y N
Are you pregnant? Y N Maybe
Number of Children:_____

Check (√) conditions you have or have had in the past:

__AIDS
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorder
__Breast Lump
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Heart Disease
__Hepatitis
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Multiple Sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate Problems
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Thyroid Problems
__Tuberculosis
__Ulcers
__Venereal Disease

Family History	Alive(√)	Deceased(√)	**Health Problems**
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling(s)	_____	_____	_____

Health Habits: Check(√) which you use and how much

__Alcohol_____ __Street Drugs_____
__Tobacco_____ __Other_____

Check(√) if your work exposes you to

__Stress __Hazardous Substances
__Heavy Lifting __Other_____

Medication Allergies: List allergies to medications or substances_____

To the best of my knowledge, the above information is complete and correct I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health

Signature of patient/legal guardian_____**Date**_____