

Date: \_\_\_\_\_

Please Write Name Here \_\_\_\_\_ Signature \_\_\_\_\_

**REVIEW OF SYSTEMS** Please answer the following questions by circling Yes or No- IF YOU HAVE TIME FILL OUT THE SOCIAL HISTORY AND HEALTH MAINTENANCE AREAS-

Any fevers or weight loss? YES NO

Any eye problems? YES NO

Any ear,nose, throat or mouth problems? YES NO

Any chest pain or irregular heart issues or swelling? YES NO

Any shortness of breath, coughing or wheezing? YES NO

Any nausea,vomiting, abdomen pain, or stool issues? YES NO

Any problems with urination in any way? YES NO

Any problems with your vagina or penis? YES NO

Any aches or muscle pains anywhere? YES NO

Any skin lesions, rashes or other problems? YES NO

Any breast problems? YES NO

Any weakness, numbness, dizziness, or tremors? YES NO

Any suicidal thoughts, sadness, depression, or anxiety? YES NO

Any bleeding problems anywhere? YES NO

Any runny nose, frequent sneezes or itchy eyes? YES NO

Any other concerns or questions you would like to discuss today? \_\_\_\_\_

Any Medications you need refilled today? \_\_\_\_\_

### **SOCIAL HISTORY**

Tobacco Use? YES NO

Seat belt use? YES NO

Any Illicit Drug use? YES NO

How often do you drink alcohol? \_\_\_\_\_

### **HEALTH MAINTENANCE**

Last Physical \_\_\_\_\_

Last Cholesterol \_\_\_\_\_

Last Prostate Check \_\_\_\_\_

Last Mammogram \_\_\_\_\_

Last Colonoscopy \_\_\_\_\_

Last Bone Density \_\_\_\_\_

Last test for blood in stool \_\_\_\_\_

Last Pap Smear \_\_\_\_\_

Do you have a living will? \_\_\_\_\_