

Any questions left blank will be considered not to be a problem or a "negative response"

REVIEW OF SYSTEMS: (Please inform the nurse if you have a problem that is not identified below.)

Are you currently or have you had problems with your : If any are checked YES please explain.

Circle

- Yes No EYES: (Blurred Vision, Double Vision, Pain, Discharge)
Yes No EARS, NOSE, THROAT: (Discharge, Hearing Loss, Smell, Pain)
Yes No CARDIOVASCULAR: (Blood Pressure, Chest Pain)
Yes No GASTROINTESTINAL: (Ulcers, Stomach, Diabetes, Digestion)
Yes No RESPIRATORY: (Asthma, Shortness of Breath, Cough, Lung Diseases)
Yes No SKIN / BREAST: (Tumors, Masses, Cancer, Lesions, Rashes, Biopsy)
Yes No ARTHRITIS: (Rheumatoid, Osteoarthritis)
Yes No NEUROLOGIC: (Numbness, Tingling, Balance)
Yes No CONSTITUTIONAL: (Weight Loss, Diet, Development)
Yes No PSYCHOLOGICAL: (Depression, Anxiety, Agitation, Mood Swings)
Yes No DISABLED: (How & When)
OTHER:

PAST MEDICAL HISTORY: Please indicate any major surgeries or hospitalizations, and if there were complications.

Table with 3 columns: Hospitalizations / Surgeries (type) / Major Injuries, Year, Complications if any

Have you ever had general anesthesia (put to sleep)? Circle YES NO If YES Where there any problems? YES NO If YES, please explain the problem:

FAMILY HISTORY: Please complete to the best of your knowledge.

Table with 4 columns: Name (MOTHER, FATHER, SISTER / BROTHER, CHILDREN), Alive, Deceased, If deceased, cause of death / Health status (Good, Poor, Excellent)

SOCIAL HISTORY: Please answer all questions.

- 1. Are you Employed? If YES, occupation: Are you a student?
2. Marital Status: Single Married Separated Widowed
3. Do you have Children? Do you live with Spouse Relatives Alone Other
4. Do you exercise? If YES, what type or kind of exercise?
5. Are you on any kind of special diet? If YES, what type or kind?
6. Have you had history of substance abuse? If YES, explain:
7. Do you smoke? If YES, how long have you smoked? How many packs per day?
8. Do you drink alcohol? If YES, how much? How long?
9. Education: Circle Jr.High School GED High School College Graduate School Other

Physicians Initials Date

PFSH + ROS Updated:

Updated Int: /Updated Int: /Updated Int: /Updated Int: