

REVIEW OF SYSTEMS / FAMILY HISTORY

Name: _____

ANY MAJOR / PERSISTENT PROBLEMS WITH:

Recent Weight Change	No	Yes	Abdominal Pain / Heartburn	No	Yes
Fever	No	Yes	Frequent Urination	No	Yes
Fatigue	No	Yes	Joint Stiffness	No	Yes
Headaches	No	Yes	Weakness of Muscles / Joints	No	Yes
Chest Pain / Angina Pectoris	No	Yes	Rash / Itching	No	Yes
Palpitations	No	Yes	Numbness or Tingling	No	Yes
Shortness of Breath	No	Yes	Nervousness	No	Yes
Swelling of Feet / Ankles	No	Yes	Bleeding / Bruising Tendency	No	Yes
Chronic / Frequent Cough	No	Yes	Phlebitis	No	Yes
Spitting up Blood	No	Yes	Hat Fever	No	Yes
Asthma / Wheezing	No	Yes	Sinus Drainage	No	Yes
Loss of Appetite	No	Yes	Diabetes	No	Yes

ANY RELATIVES (Parents, Children, Aunts / Uncles, etc...) WITH:

Heart Disease	No	Yes	Lung Disease	No	Yes
High Blood Pressure	No	Yes	Liver Disease	No	Yes
Cancer	No	Yes	Kidney Disease	No	Yes
Diabetes	No	Yes	Bleeding Disorders	No	Yes

List all medications you are currently taking or have taken in the last two weeks:

Medication:	Reason for taking medication:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHYSICIAN SIGNATURE: _____ DATE: _____

