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PATIENT REVIEW OF SYSTEMS - DETAILED HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS BY **CIRCLING** YES OR NO.
IF NOT SURE, PLEASE ANSWER AS BEST AS YOU CAN.

GENERAL

Have you had any recent weight gain?.................. YES NO
Have you had any recent weight loss? .... YES NO
Do you use tobacco in any form? .... YES NO
Do you use alcohol in any form? .... YES NO
Have you used drugs like marijuana, cocaine, or amphetamines?.................. YES NO

GENITOURINARY

Do you wet yourself?.................. YES NO
Have you ever had an infection in your urine?.................. YES NO
Have you ever had a sexually transmitted disease? .... YES NO
Have you ever had kidney pain?.................. YES NO
Have you ever had a kidney stone?.................. YES NO
Do you get up every night to urinate?.................. YES NO
Do you have to strain to empty your bladder?.................. YES NO
Have you ever had cancer in your urinary tract? .... YES NO
Do you have trouble when you try to have sex? .... YES NO

HEAD AND NERVES

Do you have trouble with headaches? .... YES NO
Do you have trouble seeing? .... YES NO
Do you have trouble hearing? .... YES NO
Has your voice changed during the last year?.................. YES NO
Do you have trouble with nosebleeds? .... YES NO
Do you have seizures/convulsions?.................. YES NO
Do you have blackout spells? .... YES NO
Have you ever had a stroke? .... YES NO
Have you ever been paralyzed?.................. YES NO
Have you ever been treated for mental illness?.................. YES NO

LUNGS

Do you have asthma, emphysema, chronic bronchitis, or COPD?.................. YES NO
Do you have a cough every day? .... YES NO
Have you ever coughed up blood? .... YES NO
Do you have shortness of breath?.................. YES NO
Have you ever had pneumonia?.................. YES NO

HEART AND BLOOD VESSELS

Have you ever had a heart attack? .... YES NO
Do you have pains in your chest?.................. YES NO
Is your heartbeat irregular?.................. YES NO
Do you get pain in your lower legs when you walk? .... YES NO

GASTROINTESTINAL

Do you vomit frequently?.................. YES NO
Have you ever vomited blood?.................. YES NO
Have you had ulcers?.................. YES NO
Have you ever passed blood with your bowel movements?.................. YES NO
Do you usually have bowel trouble? .... YES NO

OTHER

Have you ever had a blood transfusion? .... YES NO
Is there anything else you want to tell us?.................. YES NO
May we send records to your family doctor?
If so, please list doctor's name: ____________________

YOUR NAME: ____________________

YOUR SIGNATURE: ____________________

TODAY'S DATE: _____/_____/_____ M.D. SIGNATURE: ____________________