Last Name	First Name	MI	Date of Birth
Marital Status: Single , Divorced , Married , Widow/Widower		Who Lives With You?	
Employer	Occupation	What kind of work?	
Primary Care Physician	Other doctors involved with your care:		

REVIEW OF SYSTEMS; Have you or the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? o Yes o No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			**Cardiac**			**Neurologic**			**Ear, Nose, & Throat**		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			**Psychosocial**		
Weight loss			**Respiratory**			**Musculoskeletal**			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck pain			Anxiety disorders		
Ulcerative Colitis			Chronic Cough			Back pain			**Breast**		
Trouble swallowing			Hoarseness			Blood Disorders			**Lumps**		
Nausea/Vomiting			Tracheostomy			**Skin**			**Cancer**		
Heartburn			**Genitourinary**			Rash			**Please list below:**		
Abdominal Pain			Kidney Disease			Bruises			**Any symptoms/diseases**		
Hepatic			Frequent urine infection			**Ophthalmic**			**not listed above?**		
Liver Disease			**Endocrine/Metabolic**			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					