



**REVIEW OF SYSTEMS: (Please circle or add)**

**No change since last office visit**

- Constitutional- fever, weight loss, sweats, other \_\_\_\_\_
- Eyes- visual disturbance, eye pain, other \_\_\_\_\_
- Ears, Nose, Mouth, Throat- pain, hearing loss, loss of smell, difficulty swallowing, other \_\_\_\_\_
- Cardiovascular- chest pain, palpitations, other \_\_\_\_\_
- Respiratory-cough, sputum, shortness of breath, wheezing, other \_\_\_\_\_
- Gastrointestinal- abdominal pain, diarrhea, constipation, nausea, vomiting, other \_\_\_\_\_
- Musculoskeletal- weakness or paralysis in arms or legs, pain, other \_\_\_\_\_
- Integumentary- skin rashes, lesions, ulcers, other \_\_\_\_\_
- Neurological- Headache, seizure, dizziness, other \_\_\_\_\_
- Psychiatric-depression, anxiety, psychosis, other \_\_\_\_\_
- Endocrine-increased nighttime urination, nighttime thirst, heat or cold intolerance, other \_\_\_\_\_
- Hematologic/Lymphatic- enlarged lymph nodes, excessive bleeding, other \_\_\_\_\_
- Are you currently pregnant or considering getting pregnant    Yes            No

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**PMH (please circle any medical problems that you have or have been treated for in the past)**

**No change since last office visit**

High blood pressure	liver disease	cancer
Angina/coronary artery disease	kidney disease	rheumatologic disease
Heart attack	peptic ulcer	diabetes
Heart failure	other GI illness	skin condition
Emphysema or asthma	bleeding disorder	depression
Stroke	taking anticoagulants	migraine headache
Seizures	thyroid disease	other (specify) _____

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**Family History (please list medical problems of biological family members)**

**No change since last office visit**

Mother \_\_\_\_\_

Father \_\_\_\_\_

Sister(s) \_\_\_\_\_

Brother(s) \_\_\_\_\_

Children \_\_\_\_\_

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**Social History (please complete information below)**

**No change since last office visit**

- Do you drink alcohol? Y / N            Do you smoke cigarettes? Y / N            Employed Y / N
- Marital History:    single            married            remarried            divorced            separated            widowed
- Litigation history: is there any litigation in progress in regard to your pain condition? Yes / No
- Do you have a history of drug and/or alcohol abuse? Yes / No    (If yes, circle all that apply)  
                 Alcohol            marijuana            cocaine            heroin            medthedrine            other \_\_\_\_\_