COMPLETE THIS FORM BEFORE EACH APPOINTMENT.

Today's Date: ________________________

Print Name: ____

Date of Birth: _________________________

Referred by: ____

Reason for visit: ____

Review of Systems:

Question		
Are you tired all the time?…………………………………………………...……………….....	Y	N
Do you have night sweats?……………………………………………………………………...	Y	N
Do you have fever, chills, or body aches?……………………………………………………....	Y	N
Have you had any weight loss or weight gain? ………………………………………………..	Y	N
Do you have headaches, vertigo, light-headedness, or nosebleeds?……………………….…...	Y	N
Do you have any dental problems?……………………………………………………………..	Y	N
Do you have a stiff neck or thyroid mass?…………………………………………………..….	Y	N
Do you have breast lumps, tenderness, swelling, or nipple discharge?……………………….…..	Y	N
Do you have chest pains, irregular heartbeat, rapid heartbeat, or leg swelling?…………………..	Y	N
Do you have shortness of breath, wheezing, cough, or hoarseness?………………………………	Y	N
Do you have nausea, vomiting, diarrhea, excessive belching, or abdominal pain?	Y	N
Is there ever blood in your stools or do you have hemorrhoids?…………………………….……	Y	N
Do you have difficulty with frequent urination, or have changes in urine color or odor?……….	Y	N
Do you have rashes, itching, new skin lesions, or changes in existing moles or acne?…………....	Y	N
Do you have muscular weakness, tingling, numbness, or terrors?………………………………..	Y	N
Do you have seizures?…………………………………………………………………………	Y	N
Do you have joint pain, swelling, muscle pain, limitation of motion, or back pain?……………..	Y	N
Do you have anxiety or feel depressed?………………………………………………………..	Y	N
Have you ever been treated for anxiety or depression in the past?………………………………..	Y	N
Do you have difficulty sleeping, impulsive behavior, or excessive anger?………………………	Y	N
Do you have easy bleeding or bruising?…………………………………………………………..	Y	N

Social History:

Are you (circle one) Married Single Divorced Widowed

Are you sexually active? Y N If you are not currently sexually active, have you ever been? Y N

How many partners have you had? ____________________

Have you ever had a pelvic infection or been told you have an STD? Y N

If so, which one(s)? ____

Do you smoke? Y N

If yes, how many packs/cigarettes per day? _____________ How long have you smoked? ______

Do you drink alcohol? Y N Socially

Do you use any drugs of abuse? Y N If yes, which one(s)? ________________________________

Do you go to school? Y N If so, where? ____

Do you work outside of the home? Y N If so, where? _________________________