

**FAMILY HISTORY**

I am adopted and do not know my family history.

I am unable to get my complete family history.

Age	Alive/Deceased	Medical Problems	Cause of Death
Father			
Mother			
(Siblings)			

Do any relatives have these following conditions? Relatives = parents, siblings, your children, aunts, uncles, grandparents. Check Yes or No

	Yes	No	Relative		Yes	No	Relative
Diabetes				Breast Cancer			
Stroke				Colon Cancer			
Heart Disease				Ovarian Cancer			
High Blood Pressure				Drinking Problem			
Osteoporosis				Thyroid Disease			

**REVIEW OF SYSTEMS (circle all that apply to you currently or recently)**

I am having none of the following symptoms.

<p><b>CONSTITUTIONAL</b></p> <p>Weight Loss      Fever      Poor appetite</p> <p>Weight Gain      Fatigue      Trouble sleeping</p>	<p><b>ALLERGY/IMMUNE SYSTEM</b></p> <p>Seasonal allergies      Difficulty healing      Steroid use</p> <p>New Drug Allergy      Frequent Illness</p>
<p><b>EYES</b></p> <p>Vision Changes      Burning      Glaucoma</p> <p>Double Vision</p>	<p><b>NEUROLOGICAL</b></p> <p>Numbness      Dizziness      Difficulty walking</p> <p>Headaches      Seizures      Tingling</p>
<p><b>EARS/NOSE/THROAT/MOUTH</b></p> <p>Ear aches      Sinus problems      Mouth sores</p> <p>Ring in ears      Sore throat      Dental problems</p>	<p><b>PSYCHIATRIC</b></p> <p>Depression      Disorientation      Anxiety</p> <p>Excessive mood swings      Frequent crying spells</p>
<p><b>CARDIOVASCULAR</b></p> <p>Chest pain/Angina      Palpitations      Irregular heart beat</p> <p>Difficulty breathing on exertion      Leg pain</p> <p>Swelling of legs</p>	<p><b>ENDOCRINE</b></p> <p>Dry skin      Excessive thirst      Hot flashes</p> <p>Absence of periods      Irregular periods</p> <p>Cold intolerance</p>
<p><b>RESPIRATORY</b></p> <p>Cough      Shortness of breath      Wheezing</p> <p>Pain with breathing      Spitting up blood</p>	<p><b>HEMATOLOGIC/LYMPHATIC</b></p> <p>Anemia      Swollen glands      Enlarged lymph nodes</p> <p>Easy bruisability      Cuts do not stop bleeding</p>
<p><b>GASTROINTESTINAL</b></p> <p>Nausea/vomiting      Diarrhea      Bloating</p> <p>Bloody or Black stools      Constipation      Hemorrhoids</p> <p>Change in stools      Abdominal pain</p>	<p><b>MUSCULOSKELETAL</b></p> <p>Muscle pain      Joint Pain      Arthritis</p> <p>Muscle weakness      Back pain</p> <p>Osteoporosis      Osteopenia</p>
<p><b>GENITOURINARY</b></p> <p>Burning with urination      Incontinence      Abnormal periods</p> <p>Blood in urine      Urgency      Painful intercourse</p> <p>Increased frequency of urination      Vulvar/vaginal lump</p> <p>Vulvar/vaginal itching or swelling</p>	<p><b>BREAST/SKIN</b></p> <p>Breast lump      Milky breast discharge      Rash</p> <p>Breast pain      New skin lesion      Ulcers</p> <p>Breast discharge      Change in moles</p>

**PERSONAL SAFETY**

Has anyone close to you ever threatened you?  yes  no

Has anyone ever hit, kicked, choked or hurt you physically?  yes  no

Has anyone, including your partner, ever forced you to have sex?  yes  no

Are you afraid of your partner?  yes  no

Completed by: Patient  Office Nurse  Physician

Signature of patient \_\_\_\_\_ Date reviewed \_\_\_\_\_

Physician Signature \_\_\_\_\_