

**I. General Information**

**A. Personal**

Last Name:

First Name:

\_\_\_\_\_

\_\_\_\_\_

**B. Other Health Data**

1. How many days of work did you lose due to illness in the past year? \_\_\_\_\_

2. How many times did you see a physician for medical reasons last year? \_\_\_\_\_

**II. Review of Systems and Family History**

**A. Present Medical Problems**

1. Changes of Heart/Vascular

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

2. Changes of Eyes, Ear-Nose-Throat

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

3. Changes of Endocrine

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

## II. Review of Systems and Family History (CONT)

### 4. Changes of Pulmonary

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 5. Changes of Gastrointestinal

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 6. Changes of Genitourinary

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 7. Changes of Bone and Joint

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 8. Changes of Neuropsychiatric

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 9. Changes of Hematology

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

## II. Review of Systems and Family History (CONT)

### 10. Changes of Dermatology

You? \_\_\_\_\_

Father/Mother? \_\_\_\_\_

Brother/Sister? \_\_\_\_\_

### 11. Gynecological History

Last menstrual period? \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Last pelvic exam? \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Abnormal? \_\_\_\_\_

Pregnant? \_\_\_\_\_

Any other significant changes/surgeries?

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### 12. Breast Health

Last breast exam by a physician? \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Last mammogram? \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Any other significant changes/surgeries?

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### III. Personal Habits

**Any significant changes?**

A. Tobacco: \_\_\_\_\_

B. Alcohol: \_\_\_\_\_

C. Drugs: \_\_\_\_\_

D. Weight: \_\_\_\_\_

E. Diet/Beverages: \_\_\_\_\_

F. Exercise: \_\_\_\_\_

G. Stress and Emotional Factors: \_\_\_\_\_

\_\_\_\_\_

**Any other important information for our physician?**

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