

Review of Systems

Do you or have you had any problems related to the following symptoms? Circle Yes or No.
Please explain any Yes answers in space provided.

Name _____

Date _____

Constitutional:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N

Musculoskeletal:

Chronic Back Pain	Y	N
Chronic Neck Pain	Y	N
Sore Muscles	Y	N

Eyes:

Blurred vision	Y	N
Double vision	Y	N
Cataracts	Y	N

Integumentary/Skin:

Rash	Y	N
Persistent Itching	Y	N
Skin Cancer History	Y	N

Ears/Nose/Mouth/Throat:

Hearing Loss	Y	N
Nasal Stuffiness	Y	N
Sore Throat	Y	N

Neurological:

Numbness	Y	N
Tingling	Y	N
Dizziness		

Cardiovascular:

Chest Pain	Y	N
Swollen Ankles	Y	N
Irregular Heartbeat	Y	N

Hematologic:

Swollen Glands	Y	N
Abnormal Bleeding	Y	N
Transfusion History	Y	N

Respiratory:

Shortness of Breath	Y	N
Wheezing	Y	N
Chronic Cough	Y	N

Genitourinary:

Incontinence	Y	N
Pain with Urination	Y	N
Blood in Urine	Y	N

Gastrointestinal:

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Change in Bowels	Y	N

Physician's Signature _____

Date _____

PATIENT INFORMATION RECORD

Name: _____

Reason(s) for visit _____

Allergies:

Medications and dose:

Surgeries/Hospitalizations:

Medical History (all health problems):

Family Medical History

	Heart Problems (please describe)	Cancer (please describe)	Other Major Problems
Mother			
Father			
Sister			
Brother			

Smoking Status: Current Smoker How much? _____

Former Smoker When did you quit? _____

Never Smoked

Alcohol Status: Do you drink alcohol? YES NO How much? _____

Caffeine Status: How many caffeinated drinks do you consume daily? _____

Language: English Spanish French Other _____

Race: White Black or African American American Indian

Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Height: ___ft ___in Weight: _____ lb.

Preferred Pharmacy and Pharmacy Address: _____

Signature _____

Date _____

**RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

I have received a copy of **Adult & Pediatric Urology and Urogynecology, P.C.'s**
Notice of Privacy Practices that became effective April 14, 2003.

Date

Printed Name

Signature

Note: If signed by someone other than the patient, we need written proof of your authority.

I, _____, give my permission to Adult & Pediatric Urology, P.C.,
to give any & all medical information regarding myself to the following person(s):

Signature

Date

For office use: A signature was not obtained because: _____

