Review Of Systems

Date: _____

Name: _____ Date of Birth: _____

General:	Yes	No
Do you worry a lot about your health?	_____	_____
Do you usually feel tired and worn out?	_____	_____
Do you feel depressed a lot of the time?	_____	_____
Have you recently noticed that heat or warm weather bothers you?	_____	_____
Have you recently been drinking more water or fluids?	_____	_____
Has there been any unusual weight gain or loss recently?	_____	_____

Skin:	Yes	No
Have you noticed:		
any change in your skin color?	_____	_____
any skin rashes or itching?	_____	_____
unusually dry skin?	_____	_____
any bothersome growths on your skin?	_____	_____
any sores or wounds that do not heal?	_____	_____
any change in color or size of warts?	_____	_____

Eyes:	Yes	No
Have you had:		
any pain in your eyes?	_____	_____
glaucoma?	_____	_____
blurry vision?	_____	_____
halos around lights?	_____	_____
change in vision?	_____	_____

ENT:	Yes	No
Do you have:		
any trouble hearing?	_____	_____
ringing or buzzing in your ears?	_____	_____
earaches or discharge from your ears?	_____	_____
a lot of nasal stuffiness?	_____	_____
drainage down the back of your throat?	_____	_____
frequent or severe nosebleeds?	_____	_____
persistent hoarseness?	_____	_____
a lump in your throat?	_____	_____
a sore tongue or mouth?	_____	_____
bleeding gums?	_____	_____

Respiratory:	Yes	No
Do you have:		
frequent chest colds?	_____	_____
a constant or bothersome cough?	_____	_____
coughing of blood?	_____	_____
sputum or phlegm between colds?	_____	_____
difficulty breathing?	_____	_____
wheezing/whistling in your chest?	_____	_____

Cardiovascular:	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	_____	_____
If yes, is it when walking fast, working hard, or when excited?	_____	_____
Have you ever been told that your EKG was abnormal?	_____	_____
Do you have swelling in your feet or ankles?	_____	_____
Does your heart ever beat fast or irregularly?	_____	_____
Do you get cramps in your calf muscles when you walk?	_____	_____
Do you ever awaken at night with severe difficulty breathing?	_____	_____
Do your fingers or toes ever get cold, become numb, or get white or bluish?	_____	_____

Gastrointestinal:	Yes	No
Have you recently had any changes in your eating habits?	_____	_____
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	_____	_____
Do you tend to burp a lot?	_____	_____
Have you recently noted any trouble swallowing?	_____	_____
Do you have a lot of indigestion or heartburn?	_____	_____
Have you ever vomited blood?	_____	_____
Are you bothered with constipation?	_____	_____
Do you have frequent loose stools or diarrhea?	_____	_____
Do you pass a lot of gas?	_____	_____
Do you have a poor appetite?	_____	_____
Do you ever awake at night with the feeling of fullness under your breast bone?	_____	_____
Have you ever passed blood from your rectum?	_____	_____
Have you ever had black or tarry stool?	_____	_____
Have you noticed any recent changes in your bowel movements?	_____	_____
Do you take laxatives regularly?	_____	_____
Do you have frequent nausea and/or vomiting?	_____	_____

Genitourinary:	Yes	No
Do you have:		
anything wrong with your genitals (privates)?	_____	_____
burning or pain when urinating?	_____	_____
to pass water frequently?	_____	_____
to pass more water than you used to?	_____	_____
trouble passing water?	_____	_____
to get up at night to urinate?	_____	_____
trouble with losing urine when you cough or sneeze?	_____	_____
a problem dripping urine?	_____	_____
Have you ever passed blood in your urine?	_____	_____
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	_____	_____
MEN - Do you have prostate gland trouble?	_____	_____

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Musculoskeletal:	**Yes**	**No**
Do you have a problem with back pain?	_____	_____
Do you have pain in your legs or feet?	_____	_____
Does back pain interfere with your work or activities?	_____	_____
Do you have joint pain or stiffness?	_____	_____
Do you have trouble walking or using your hip or knee joints?	_____	_____

Central Nervous System:	**Yes**	**No**
Do you have frequent or severe headaches?	_____	_____
Do you often have spells of dizziness, faintness or lightheadedness?	_____	_____
Have you seen double?	_____	_____
Do you sometimes lose track of what happens around you for a short time?	_____	_____
Do you sometimes lose the ability to speak for a few seconds?	_____	_____
Have you recently fainted, blacked out or lost consciousness?	_____	_____
Do you have trouble remembering recent events?	_____	_____
Have you ever had convulsions or fits?	_____	_____
Do you have numbness or tingling in your head, arms or legs?	_____	_____
Do you consider yourself a nervous person?	_____	_____
Do you cry a lot for no reason?	_____	_____
Have you ever had an urge to commit suicide?	_____	_____
Do you ever hear voices or see people when no one is around?	_____	_____
Do you ever have a feeling that someone is trying to harm you?	_____	_____

Personal Habits:	**Yes**	**No**
Do you regularly smoke:		
Cigarettes:	_____	_____
How many per day?_____		
For how many years?_____		
Pipe, Cigars or use Chewing Tobacco:	_____	_____
For how many years?_____		
Are you a former smoker/tobacco user?	_____	_____
If so, how long ago did you quit?_____		
Do you drink:		
Hard Liquor:	_____	_____
1-3 oz per day_____over 3 oz per day_____		
Beer:	_____	_____
1 bottle a day_____2 bottles_____3 or more_____		
Wine:	_____	_____
1 glass a day_____2 glasses_____3 or more_____		
Do you drink coffee?	_____	_____
Do you drink 3 or more cups a day?	_____	_____
Do you have difficulty sleeping?	_____	_____
If yes, how often?_____		
Do you awaken very early in the morning without an apparent cause and find it difficult to go back to sleep?	_____	_____
If yes, how often?_____		
Do you exercise?	_____	_____
# of days a week_____Minutes a day_____		
If you exercise, how intense is your exercise?		
Light____Moderate____Heavy____Very Heavy____		
Do you wear a seat belt when traveling in a car?	_____	_____
Are you sexually active?	_____	_____
Have you had more than one partner in the past 2 years?	_____	_____
Do you protect against STD's?	_____	_____
Do you use contraception/birth control?	_____	_____

Women Only	**Yes**	**No**
Did your menstrual cycle start before you were 10?	_____	_____
Did your menstrual cycle start after your were 15?	_____	_____
Are your menstrual cycles irregular?	_____	_____
Are your periods less frequent than every 4 weeks?	_____	_____
Are your periods more frequent than every 4 weeks?	_____	_____
Do you use more than 10 pads or have to use a super size pad or tampon for your periods?	_____	_____
Do you pass clots with your periods?	_____	_____
Do you become bloated or gain weight just before your periods?	_____	_____
Have you passed the menopause or change?	_____	_____
Do you have hot flashes?	_____	_____
Have you had an abortion or miscarriage?	_____	_____
Have you had lumps in your breast?	_____	_____
Have you had any discharge from your nipples?	_____	_____
Have you used an intrauterine device (IUD)?	_____	_____
Have you used other birth control measures?	_____	_____

GMS Florida West Coast, Inc.

A Physician Group Practice

Preventive/Physical

We applaud your efforts to maintain your health by utilizing your preventive care physical benefits. In today's age of medicine and government involvement, these benefits continue to change, unfortunately covering less and less under preventive care. Your exact benefits are not only determined by what insurance company you have but also what plan you have chosen through your company's individual offerings. Your company may offer multiple different plan choices, each having different preventive care benefits. This makes it impossible for our office to accurately know your benefits.

Medically we feel that an EKG and certain lab tests (CBC, CMP, Lipid Panel, and TSH) are appropriate and have been previously covered under preventive care. However, you are welcome to check your individual benefit package through your employer or insurance company to see what your plan specifically covers under your current preventive care benefits.

Please realize that all insurance companies and Medicare agree that preventive care does not include any procedures or treatments including the writing of prescriptions. Further, many insurances will not cover specialty lab tests such as Testosterone, Vitamin D or hormone levels under preventive care either. We are providing you this information so that you are aware of preventive care coverage issues which currently exist and of your possible financial responsibilities. Please sign below acknowledging that these issues have been brought to your attention.

We thank you for allowing our office to provide your health care and hope to do so in the future.

_____ _____

Patient Signature Date