

Current Review of Systems

Patient's name _____ **Date** _____ **SSN:** _____

Have there been any changes in your health and medical status concerning any of the following systems:

System	Examples (Circle item if applies)	Describe other problems	None
Constitutional	Fever, weight loss, weight gain, fatigue		
Eyes	Blurred vision, double vision		
Ears, Nose, Throat	Pain, bleeding, congestion, hoarse		
Heart (Cardiovasc.)	Heart palpitations, high blood pressure		
Lung (Respiratory)	Asthma, congestion, pneumonia		
Gastrointestinal	Ulcers, diarrhea, black stools, cramps		
Genitourinary	Pelvic pain, bleeding, incontinence		
Musculoskeletal	Muscle, joint or bone pain, swelling		
Skin & Breast	Changing moles, new lumps		
Neurological	New headaches or sensations		
Psychiatric	Depression, anxiety, social problems		
Endocrine	Thyroid problems, diabetes		
Hematologic/Lymph	Coagulation/lymph node problems		
Allergic/Immunol.	Hay fever, drug allergies, HIV		

Have there been any changes concerning your family's or relative's medical history, such as any deaths, newly diagnosed illnesses, cancers, or hereditary disease? If so, please indicate these below. If no changes, check here ____.

Have there been any changes concerning your employment status, your spouse's employment status, or your marital status? Yes No If yes, please record new information:

Employer Name _____ Address _____ Tele _____

Spouse's New Employer _____ Address _____ Tele _____

Marital Status: Married Single Divorced Widowed

Who is your current insurance carrier? _____

Policy holder: _____ Policy # _____

Are you covered by any other medical insurance plans? (Please mark appropriate blank) **Yes** **No**

If you or any of your dependents are covered under any other group medical plan, this section must be completed:

Other health Plan Carrier _____ Policy Holder: _____

List individuals covered: _____

Carrier's Address _____ Tele _____

Policy # _____ Effective Date/Termination Date: _____

I hereby certify that the above information and statements are true and accurate. I understand my appointment today is for a routine physical exam and will be billed as such. I am willing to accept responsibility for the charges if my insurance company chooses not to cover this service.

Signature: _____ Date: _____

Thank you for taking the time to complete this form. It will **help us to provide** more **complete** and **comprehensive medical care for you.**