**REVIEW OF SYSTEM**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:**

**MARRIED: SINGLE: DIVORCED:**

**NO. OF CHILDREN: TOBACCO USE: YES/NO HOW MUCH?**

ALCOHOL USE: HOW MUCH PER DAY?

**PAST ILLNESSES OF YOURSELF AND FAMILY:**

 **YOU/YOUR FAMILY YOU/YOUR FAMILY YOU/YOUR FAMILY**

ALCOHOL

ALCOHOLISM HIGH BLOOD PRESSURE STROK

ANEMIA KIDNEY DISEASE SUICIDE ATTEMPT

ASTHMA LIVER DISEASE THYROID DISEASE

CANCER/TUMOR HEPATITIS TUBERCULOSIS, TB

DIABETES LUNG DISEASE ULCER IN GI TRACT

DRUG ABUSE MENTAL ILLNESS VENEREAL DISEASE

DEPRESSION OSTEOARTHRITIS HIGH CHOLESTEROL

EPILEPSY/SEIZURES OSTEOPOROSIS HIV/IMMUNE DX

GLAUCOMA PHLEBITIS

HEART DISEASE

RHEUMATIC ARTHRITIS

**PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNATURE/REVIEWINGPHYSICIAN**

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**NEW PATIENT- PLEASE COMPLETE THE FOLLOWING**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS, VITAMINS, AND SUPPLIMENTS

MEDICINE NAME HOW TAKEN? WHO PRESCRIBES? NEED RX

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO

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**PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:**

NAME CITY/STATE PROBLEM CARED FOR: STILL SEEING? REFERRAL?

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**ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS**

NAME OF MEDICATION: ADVERSE REACTION

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**ADDITIONAL INFORMATION:**

LAST MAMMOGRAM? \_\_\_\_\_\_\_\_\_\_\_ WHERE? \_\_\_\_\_\_\_\_\_LAST PAP? \_\_\_\_\_\_\_\_\_\_\_GYN? \_\_\_\_\_\_\_\_\_

DR ARCENAS TO PERFORM FUTURE PAPS? YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST COLONOSCOPY? \_\_\_\_\_\_\_\_\_\_NORMAL? \_\_\_\_\_\_DR? \_\_\_\_\_\_\_\_\_\_REPEAT DATE? \_\_\_\_\_\_\_\_\_\_\_

APPROXIMATE DATE OF LAST BLOODWORK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RECTAL EXAM? \_\_\_\_\_\_\_\_\_\_\_\_\_

VACCINE DATES:

TETANUS? \_\_\_\_\_\_\_\_\_\_PNEUMONIA? \_\_\_\_\_\_\_\_\_\_FLU? \_\_\_\_\_\_\_\_\_\_\_HEPATITIS B SERIES? \_\_\_\_\_\_\_