

PATIENT NAME:

Date Of Birth:

DOS

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REVIEW OF SYSTEMS:

Do you have profuse night sweats, weight loss or temperature?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you gained weight excessively?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Are you tired after usual activities and is it a change for you?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed blurring or loss of vision lately?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have double vision or recent onset?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Is your throat sore or have you noted sores in mouth, or hoarseness?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you feel your sinuses are congested?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have ringing of ears, hearing loss or vertigo?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have cough?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have phlegm or blood in sputum ?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have chest pain which increases on respiration?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have shortness of breath, or wheezing?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have chest pain at rest or exercise?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have swelling of ankles?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have dizziness or palpitation?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have shortness of breath on exercise, or on lying down?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have difficulty or pain on swallowing?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have nausea or vomiting?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have constipation, diarrhea or change in bowel habits?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have heart burn?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you notices black stools or bright red blood in stools?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have abdominal pain?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed your urinary stream to be weak, or do you have hesitancy or dribbling of urine?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have burning or urination?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed blood in the urine?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have excessive urination at night?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have joint pains or morning stiffness lasting 30 min or more?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Is it difficult to get up from chair?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have back pain?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have swelling of one leg/arm or muscle cramps?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have new onset headaches?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have memory loss?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have weakness or paralysis or numbness of half of your body?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have tingling or numbness?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have rash with or without itching?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Are there new moles on your body or the moles changing?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed hair loss?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed blisters on your skin?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have anxiety, depression or panic attacks?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Are unable to fall asleep or wake up early in morning?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Are your menstrual cycles irregular, heavy or intermittent?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
If you are post menopausal, have you noticed any vaginal bleeding?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you had excessive pregnancy losses?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed any breast lump? (ANSWER IF APPLICABLE)	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed any testicular swelling? (IF APPLICABLE)	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you have sexual dysfunction?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Do you bleed excessively or bruise spontaneously?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed any lymph gland enlargement?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____
Have you noticed any lump on your body?	<input type="checkbox"/> _yes	<input type="checkbox"/> _no	_____

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INFORMATION ABOUT YOUR PAST MEDICAL HISTORY

- Have you had any Eye related problems like Cataracts, Glaucoma or other Visual impairments leading to Loss of vision? YES NO
- Have you had Hoarseness, Vertigo or Chronic Sinus problems? YES NO
- Have you been diagnosed or treated for Cancer of Head, Neck or throat region? YES NO
- Have you been diagnosed with Anemia, Thalassemia or bleeding disorder? YES NO
- Have you been diagnosed with Clotting disorder or blood clot in Legs or Lung? YES NO
- Have you been diagnosed with Leukemia, Lymphoma or Multiple Myeloma? YES NO
- Have you been diagnosed with Rheumatoid Arthritis, Lupus, Fibromyalgia, Gout, Scleroderma or Sjogren's syndrome? YES NO
- Have you had Osteoporosis, loss of height, or degenerative joint or spine disease? YES NO
- Have you been diagnosed with cancer originating in or going to bones? YES NO
- Have you had Chronic Kidney problems or Kidney Failure? YES NO
- Have you been diagnosed with Prostate, Bladder or Kidney cancer? YES NO
- Have you been diagnosed with Uterine, Ovarian or Breast Cancer? YES NO
- Have you had Chronic Liver disease, Hepatitis, or Cirrhosis of Liver? YES NO
- Have you had Hiatal hernia, GERD or Peptic Ulcer disease? YES NO
- Have you had Ulcerative colitis or Crohn's disease or Irritable Bowel Disease? YES NO
- Have you been diagnosed with cancer originating in Liver, Stomach, Colon, Pancreas Gall Bladder or Esophagus? YES NO
- Have you had Seizures, Stroke, TIA, Paralysis or Neuropathy? YES NO
- Have you had Chronic Bronchitis, Emphysema, Asthma, Sleep apnea, Pleurisy or TB? YES NO
- Have you been diagnosed with Lung Cancer or cancer going to lungs? YES NO
- Have you had High Blood Pressure, Heart Attack or Congestive Heart Failure? YES NO
- Have you had disease of Blood vessels of legs, brain or aorta or varicose Veins? YES NO
- Have you had Chronic skin problems or Eczema or Psoriasis or have you had melanoma? YES NO
- Have you had Diabetes or its related problems like Eye changes, Kidney Disease or Neuropathy? YES NO
- Have you had Thyroid problems? YES NO
- Have you had high cholesterol? YES NO
- Have you been diagnosed with Maniac Depressive Illness, Schizophrenia, or had anxiety, depression, or panic attacks. YES NO
- Have you been diagnosed with any Cancer not mentioned above? YES NO
If Yes- Site of Cancer where it originated _____
- Have you received Chemotherapy in the past? YES NO
- Have you received Radiation therapy in the past? YES NO

PHYSICIAN'S REMARKS _____

