**Name _____ Age ____DOB__/__/___**

**Ht _____ Wt _____Phone_____-_____-_____**

**Address:_____**

**_____**

**Reason for visit: _____**

**Review of Systems: (**circle **yes** or **no)**

**General:**

| | | | | | |
|---|---|---|---|---|---|
| Fevers | Y | N | Chills | Y | N |
| Wt. Loss | Y | N | Wt. Gain | Y | N |
| Weakness | Y | N | Fatigue | Y | N |

**Head:**

| | | | | | |
|---|---|---|---|---|---|
| Headaches | Y | N | Sweats | Y | N |
| Pain | Y | N | Dizziness | Y | N |
| Fainting | Y | N | Head Injury | Y | N |

**Eyes:**

| | | | | | |
|---|---|---|---|---|---|
| Double vision | Y | N | Dry Eyes | Y | N |
| Contacts | Y | N | Eyeglasses | Y | N |
| Pain | Y | N | Tearing | Y | N |

**ENT:**

| | | | | | |
|---|---|---|---|---|---|
| Running Nose | Y | N | Hayfever | Y | N |
| Nose trauma | Y | N | Hearing loss | Y | N |
| Ear infections | Y | N | | | |

**Respiratory:**

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Y | N | CPAP | Y | N |
| COPD | Y | N | TB | Y | N |

**Cardiovascular:**

| | | | | | |
|---|---|---|---|---|---|
| Chest Pain | Y | N | Heart Attack | Y | N |
| Leg swelling | Y | N | Hypertension | Y | N |
| Palpitations | Y | N | Blood clots | Y | N |

**Gastrointestinal:**

| | | | | | |
|---|---|---|---|---|---|
| Abdominal pain | Y | N | Diarrhea | Y | N |
| Constipation | Y | N | Bloody Stool | Y | N |
| Reflux | Y | N | Hepatitis | Y | N |

**Musculoskeletal:**

| | | | | | |
|---|---|---|---|---|---|
| Arthritis | Y | N | Joint Surgery | Y | N |
| Carpal tunnel | Y | N | Neck pain | Y | N |
| Back pain | Y | N | Paralysis | Y | N |

**Skin:**

| | | | | | |
|---|---|---|---|---|---|
| Skin Cancer | Y | N | Precancer | Y | N |
| Melanoma | Y | N | Itching | Y | N |
| Bleeding lesion | Y | N | Painful lesion | Y | N |

**Psychiatric:**

| | | | | | |
|---|---|---|---|---|---|
| Depression | Y | N | Anxiety | Y | N |
| Hallucinations | Y | N | Suicidality | Y | N |

**Neurological**

| | | | | | |
|---|---|---|---|---|---|
| Stroke | Y | N | Seizures | Y | N |
| Head Injury | Y | N | Paralysis | Y | N |

**Endocrine:**

| | | | | | |
|---|---|---|---|---|---|
| Cold intolerance | Y | N | Heat intolerance | Y | N |
| Wt. Loss | Y | N | Wt. Gain | Y | N |
| Goiter | Y | N | Fatigue | Y | N |

**Breasts:**

| | | | | | |
|---|---|---|---|---|---|
| Pain | Y | N | Infections | Y | N |
| Cancer | Y | N | Discharge | Y | N |
| Heaviness | Y | N | Self examination | Y | N |

| **Allergies:** | **Reaction:** |
|---|---|
| | |
| | |
| | |

| **Medications:** | **Dose:** | **Frequency:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Family:** | **Alive?** | | **Medical History:** |
|---|---|---|---|
| Father | Y | N | |
| Mother | Y | N | |
| Sister | Y | N | |
| Brother | Y | N | |

**Patient Medical Hx:**

| | | | | | |
|---|---|---|---|---|---|
| Anemia | Y | N | Hypertension | Y | N |
| Cancer | Y | N | HIV | Y | N |
| Hepatitis | Y | N | COPD | Y | N |
| Stroke | Y | N | Thyroid Dz | Y | N |
| Heart Disease | Y | N | Diabetes | Y | N |
| Asthma | Y | N | Seizures | Y | N |

Other _____

| **Social Hx:** | | | **Amount?** | **#Years?** | **Year Quit ?** |
|---|---|---|---|---|---|
| Cigar / cigarette | Y | N | | | |
| Alcohol | Y | N | | | |
| Drugs | Y | N | | | |

| **Surgery:** | **When:** | **Surgery:** | **When:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**I consent to the use of photographs before, during and after procedures for purposes of medical education, insurance billing, lectures, and promotion of Dr. Newman's practice and these photos shall never contain my name or other identifiable data.**

_____ _____

**Signature** **Date**

**These photos may be used on Dr. Newman's Website.**

_____ _____

**Signature** **Date**