

Comprehensive Review of Systems

Sweats _____ Chills _____ Fever _____ Trouble Sleeping _____ Appetite Change _____ Weight Change _____ Abuse, Fear, Harm _____ Depression _____ Anxiety, Panic _____ Vision Changes _____ Eye Pain _____ Headaches _____ Hearing Problems _____ Ringing in Ears _____ Hoarseness _____ Sinus, Nose Bleeds _____ Smell, Bad Taste _____ Oral Lesions _____ Dry Mouth _____ Teeth Gums _____ Neck or Jaw Pain _____ Thyroid, Goiter _____ Swollen Glands _____ Tics, Tremors _____ Memory Loss _____ Seizures _____ Left or Right Handed _____	Swallowing problem _____ Heartburn _____ Bloating _____ Ulcers _____ Abdominal pain _____ Nausea _____ Vomiting _____ Diarrhea _____ Constipation _____ Bowels irregular _____ Blood in stool _____ Food intolerances _____ Jaundice _____ Hemorrhoids _____ Sexually Active _____ Multiple partners _____ High risk sex _____ Infections _____ Change in sex drive _____ Menstrual disorder _____ Incontinence _____ Frequent urination _____ Urge to urinate _____ Painful urination _____ Blood in urine _____ Discharge _____ Groin itching _____ Awaking to urinate _____ Change in stream _____ Last period _____ Pregnancies _____ Live births _____ Abortions _____	Shortness of breath _____ Cough _____ Sputum _____ Coughed up blood _____ Choking at night _____ Asthma _____ Breathless when flat in bed _____ Snoring _____ Breathless when walking _____ Chest pressure _____ Chest pain _____ Wake up breathless _____ Ankle swelling _____ Leg cramping _____ Varicose veins _____ Cold feet or hands _____ Passing out _____ Falls _____ Joint stiffness _____ Joint pain _____ Joint swelling _____ Muscle aches _____ Weakness _____ Change in moles _____ Change in nails _____ Change in hair _____ Rashes, bumps, bruises _____ Fractures _____ Numbness _____ Tingling _____ Low back pain _____ Blood clots, Phlebitis _____ Deformity, Amputation _____	DESCRIBE
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FEMALES ONLY ---- MENSTRUAL HISTORY

Age of Onset _____ Frequency _____ Duration _____

Problems _____

of pregnancies _____ # of children _____ Contraception _____

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____

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Name _____ Date of birth _____

Current Medical Conditions

Past Medical Condition

Surgeries None _____

Medications None _____

Allergies None _____

Social History

Tobacco _____ Alcohol _____

Drugs _____ Caffeine _____

Family History _____

Immunizations Chickenpox-disease or shot _____ Tetanus _____

flu _____ Pneumonia _____