

JOHN R PEDROTTY M.D.

**Name of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Chart: #** \_\_\_\_\_

**Review of Systems: Are you concerned about (circle concerns):** **Yes** **No** **Explain:**

1. eating habits, weight loss, lack of energy, sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. eye pain, redness, tearing, drainage, blurred or loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. ear, nose, mouth, throat, sinus problems, loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. heart problems, chest pain, high blood pressure, leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. lung problems: difficult breathing, wheezing, infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. abdominal pain, vomiting, indigestion, excessive gas	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. diarrhea, constipation, blood in stools, hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. kidney or bladder problems, infections, blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. joint pain, stiffness, swelling, muscle pain, weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. headaches, dizziness, numbness, weakness, seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. stress, anxiety, sadness, depression, suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. allergies: food, hay fever, asthma, increased infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. (Women) breast, menstruation, irregular bleeding, hot flashes, pain or bleeding with intercourse, other sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you now take or have you taken hormone therapy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
List approximate date of last menstrual period _____	Pap Test _____	Mammogram _____	
14. (Men) lesions or swelling on penis, scotum or testicles; difficulty urinating, enlarged prostate, difficulty getting or sustaining and erection, other sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had a PSA (prostate) test? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Do you exercise for 30 minutes? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seldom			_____
16. Do you take calcium, multivitamins, or folic acid?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Do you smoke, drink alcohol, or use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Use CODE if patient or family member has OR has had any of the following problems:

**P**—Patient **M**—Mother **F**—Father **C**-Child **S**-Sibling **GM**—Grandmother **GF**—Grandfather **A**—Aunt **U**—Uncle

1 <input type="checkbox"/> _____ Allergies	11 <input type="checkbox"/> _____ High Cholesterol	21 <input type="checkbox"/> _____ Cancer
2 <input type="checkbox"/> _____ Drug Allergies	12 <input type="checkbox"/> _____ High Blood Pressure	22 <input type="checkbox"/> _____ Neurological/Seizures
3 <input type="checkbox"/> _____ Eczema/Skin Prob's	13 <input type="checkbox"/> _____ Heart Attack/Stroke	23 <input type="checkbox"/> _____ Arthritis
4 <input type="checkbox"/> _____ Asthma/Lung Prob's	14 <input type="checkbox"/> _____ Other Heart Problems	24 <input type="checkbox"/> _____ Phlebitis
5 <input type="checkbox"/> _____ Respiratory Infections	15 <input type="checkbox"/> _____ Anemia/Blood Disorders	25 <input type="checkbox"/> _____ Hereditary Prob's
6 <input type="checkbox"/> _____ Eye or Visual Prob's	16 <input type="checkbox"/> _____ Diabetes before 50 yrs	26 <input type="checkbox"/> _____ Emotional/Behavioral
7 <input type="checkbox"/> _____ Ear Problems/Deafness	17 <input type="checkbox"/> _____ Thyroid/Endocrine Prob's	27 <input type="checkbox"/> _____ Mental Illness
8 <input type="checkbox"/> _____ Tuberculosis	18 <input type="checkbox"/> _____ Obesity	28 <input type="checkbox"/> _____ Mental Retardation
9 <input type="checkbox"/> _____ Liver Disease	19 <input type="checkbox"/> _____ Bladder/Kidney Prob's	29 <input type="checkbox"/> _____ Drug/Alcohol Abuse
10 <input type="checkbox"/> _____ Immunity Prob's/HIV	20 <input type="checkbox"/> _____ Stomach/GI Prob's	30 <input type="checkbox"/> _____ Other

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