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	☐	☐	
2. eye pain, redness, tearing, drainage, blurred or loss of vision	☐	☐	
3. ear, nose, mouth, throat, sinus problems, loss of hearing	☐	☐	
4. heart problems, chest pain, high blood pressure, leg swelling	☐	☐	
5. lung problems: difficult breathing, wheezing, infections	☐	☐	
6. abdominal pain, vomiting, indigestion, excessive gas	☐	☐	
7. diarrhea, constipation, blood in stools, hemorrhoids	☐	☐	
8. kidney or bladder problems, infections, blood in urine	☐	☐	
9. joint pain, stiffness, swelling, muscle pain, weakness	☐	☐	
10. headaches, dizziness, numbness, weakness, seizures	☐	☐	
11. stress, anxiety, sadness, depression, suicidal thoughts	☐	☐	
12. allergies: food, hay fever, asthma, increased infections	☐	☐	
13. (Women) breast, menstruation, irregular bleeding, hot flashes, pain or bleeding with intercourse, other sexual concerns	☐	☐	
Do you now take or have you taken hormone therapy?	☐	☐	
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	☐	☐	
Have you had a PSA (prostate) test? When?_____	☐	☐	
15. Do you exercise for 30 minutes? ☐ Daily ☐ Weekly ☐ Seldom			
16. Do you take calcium, multivitamins, or folic acid?	☐	☐	
17. Do you smoke, drink alcohol, or use recreational drugs?	☐	☐	

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 ☐ _____Allergies	11 ☐_____High Cholesterol	21 ☐ _____Cancer
2 ☐ _____Drug Allergies	12 ☐_____High Blood Pressure	22 ☐ _____Neurological/Seizures
3 ☐ _____Eczema/Skin Prob's	13 ☐ _____ Heart Attack/Stroke	23 ☐ _____Arthritis
4 ☐ _____ Asthma/Lung Prob's	14 ☐ _____Other Heart Problems	24 ☐ _____Phlebitis
5 ☐ _____Respiratory Infections	15 ☐ _____Anemia/Blood Disorders	25 ☐ _____Hereditary Prob's
6 ☐ _____Eye or Visual Prob's	16 ☐ _____Diabetes before 50 yrs	26 ☐ _____Emotional/Behavioral
7 ☐ _____Ear Problems/Deafness	17 ☐ _____Thyroid/Endocrine Prob's	27 ☐ _____Mental Illness
8 ☐_____ Tuberculosis	18 ☐ _____Obesity	28 ☐ _____Mental Retardation
9 ☐_____ Liver Disease	19 ☐ _____Bladder/Kidney Prob's	29 ☐ _____Drug/Alcohol Abuse
10☐_____ Immunity Prob's/HIV	20 ☐ _____Stomach/GI Prob's	30 ☐ _____Other