

Patient Name:	Date: / /
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List Current Medications:		List Operations/Hospitalizations/Injuries	
Drug Name	Dosage	Reason	Date

SOCIAL HISTORY

Habits during pregnancy			
Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seat Belt Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Regular Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

REVIEW OF SYSTEMS

Please check (X) if any of the following apply to you now or in the past:							
	Now	Past	Notes		Now	Past	Notes
1. Constitutional				7. Gastrointestinal			
Fever				Diarrhea			
Severe fatigue				Bloody stool			
2. Eyes				Nausea/vomiting			
Double vision				Constipation			
Spot before eyes				8. Skin/Breast			
Vision changes				Masses			
3. Ears/Nose/Throat				Rash			
Ear aches				9. Neurological			
Ringing in ears				Dizziness			
Sinus problems				Seizures			
Sore throat				Numbness			
Mouth sores				Trouble walking			
Dental problems				10. Psychiatric			
4. Cardiovascular				Depression/Anxiety			
Chest pain				Other			
Swelling of legs				11. Hemotologic			
Palpitations of heart				Bruises, frequent			
5. Respiratory				Bleeding does not stop			
Wheezing				Enlarged lymph nodes			
Spitting up blood				12. Genitourinary			
Shortness of breath				Blood in urine			
6. Endocrine				Urgency			
Dry skin							
Abnormal thirst							

Completed by: Patient Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Follow up reviews:

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____