

## REVIEW OF SYSTEMS

Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Do you smoke? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

Do you take blood thinners/anti-coagulants? \_\_\_\_\_

Do you have a history of any of the following illnesses? (Check all applicable)

- |  |   |
|--|---|
| <input type="checkbox"/> Heart disease/Irregular heartbeat | <input type="checkbox"/> Problems with digestion                |
| <input type="checkbox"/> Stroke/Vascular disease           | <input type="checkbox"/> Stomach problems (ulcer, hernia, etc.) |
| <input type="checkbox"/> Liver disease                     | <input type="checkbox"/> Blood infections                       |
| <input type="checkbox"/> Kidney disease                    | <input type="checkbox"/> Cancer                                 |
| <input type="checkbox"/> Eye disease                       | <input type="checkbox"/> Problems sleeping                      |
| <input type="checkbox"/> Problems with high blood pressure | <input type="checkbox"/> Diabetes                               |
|  | <input type="checkbox"/> Arthritis                              |

If you checked any of the above, please describe: \_\_\_\_\_

\_\_\_\_\_

If you checked any of the above, please list the doctor treating you for the described condition:

\_\_\_\_\_

\_\_\_\_\_

Is there a family history that would be relevant to your treatment at the present time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any medications that you are taking at the present time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any previous surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you live alone or with family? \_\_\_\_\_