Washington Township Medical Foundation
Part of Washington Hospital Healthcare System
2557 Mowry Ave, Ste 30
Fremont, CA 94538
510-793-2880

REVIEW OF SYSTEMS

Do you have or have had any of the following problems?

Yes	No		Yes	No		Any other problems? Please List:
❑	❑	Abnormal Scarring	❑	❑	Heart Murmur	
❑	❑	AIDS or HIV related illness	❑	❑	Hepatitis	
❑	❑	Alcoholism	❑	❑	High Blood Pressure	
❑	❑	Anemia/Sickle cell disease	❑	❑	Irregular Heart Beat	
❑	❑	Arthritis	❑	❑	Jaundice	
❑	❑	Artificial heart valve	❑	❑	Joint Swelling	
❑	❑	Asthma/COPD/lung disease	❑	❑	Kidney/Bladder Disease	
❑	❑	Birth defects	❑	❑	Mental Illness	
❑	❑	Bleeding disorder	❑	❑	Migraines	
❑	❑	Blood transfusion	❑	❑	Mitral Valve Prolapse	
❑	❑	Cancer	❑	❑	Nausea/Vomiting	
❑	❑	Chest pain	❑	❑	Nervousness/anxiety	
❑	❑	Circulation problems	❑	❑	Pacemaker	
❑	❑	Cold sores	❑	❑	Parkinson's Disease	
❑	❑	Congestive heart failure	❑	❑	Psychiatric problems	
❑	❑	Diabetes	❑	❑	Reflux	
❑	❑	Difficulty urinating	❑	❑	Rheumatic Fever	
❑	❑	Drug addiction	❑	❑	Sinus/Allergy Problems	
❑	❑	Emphysema	❑	❑	Skin Problems	
❑	❑	Epilepsy/seizures	❑	❑	Skin Rashes	
❑	❑	Fainting	❑	❑	Stomach Ulcers	
❑	❑	Fatigue	❑	❑	Stomach/Intestine/Bowel Disorder	
❑	❑	Glaucoma	❑	❑	Stroke/paralysis	
❑	❑	Gout	❑	❑	Tuberculosis	
❑	❑	Hay Fever	❑	❑	Thyroid Disease	
❑	❑	Head Injury	❑	❑	Venereal Disease	
❑	❑	Headache	❑	❑	Weight Loss/weight gain	
❑	❑	Heart Disease/heart attack				

Do you have any Pets? ❑ Yes ❑ No If yes, what type? _____
Have you recently traveled or plan to travel? ❑ Yes ❑ No If yes, where? _____

Social History

Do you smoke? ❑ Yes ❑ No If yes, how many packs/cigars per day? _____ How Long? _____
Do you drink alcohol? ❑ Yes ❑ No If yes, how much? _____
Do you use any illicit drugs? ❑ Yes ❑ No If yes, what? _____

(continued on Page 2) ➔

Family History

Have any blood relative had any of the following? (Please check appropriate and indicate relative)

❑ Heart Disease _____ ❑ Thyroid Problems_____ ❑ TB _____
❑ Glaucoma _____ ❑ Cancer _____ ❑ Stroke _____
❑ Epilepsy _____ ❑ High Blood Pressure _____ ❑ Asthma _____
❑ Bleeding Problems _____ ❑ Diabetes _____ ❑ Other _____

FOR WOMEN ONLY: Are you Pregnant? ❑ Yes ❑ No How Many Months? _____
Are you Breast Feeding? ❑ Yes ❑ No

Past Medical History _____

Past Surgical History _____

Medications _____

Allergies _____

Physician Signature: _____