Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

PLACE PATIENT LABEL HERE

Patient Name: _____

REVIEW OF SYSTEMS

	Symptom				
General	Activity Change	Yes	CARDIO	Chest Pain	Yes
	Appetite Change	Yes		Leg swelling	Yes
	Chills	Yes		Palpitations	Yes
	Diaphoresis	Yes	GI	Abdominal distention	Yes
	Fatigue	Yes		Abdominal pain	Yes
	Fever	Yes		Anal bleeding	Yes
	Unexpected Weight gain	Yes		Blood in stool	Yes
HENT	Facial swelling	Yes		Constipation	Yes
	Neck Pain	Yes		Diarrhea	Yes
	Neck Stiffness	Yes		Nausea	Yes
	Ear discharge	Yes		Rectal pain	Yes
	Hearing loss	Yes		Vomiting	Yes
	Ear Pain	Yes	URINARY	Dificulty urinating	Yes
	Tinnitus	Yes		Dysuria	Yes
	Nosebleeds	Yes		Flank pain	Yes
	Congestion	Yes		Frequency	Yes
	Postnasal drip	Yes		Genital sore	Yes
	Sneezing	Yes		Hematuria	Yes
	Sinus pressure	Yes		Menstrual problem	Yes
	Dental problem	Yes		Pelvic pain	Yes
	Drooling	Yes		Urgency	Yes
	Mouth sores	Yes		Vaginal bleeding	Yes
	Sore throat	Yes		Vaginal discharge	Yes
	Trouble swallowing	Yes		Penile Dicharge	Yes
	Voice change	Yes		Penile pain	Yes
EYES	Eye discharg	Yes	MUSCLES	Arthralgias (joint pain)	Yes
	Eye itching	Yes		Back pain	Yes
	Eye pain	Yes		Gait problem	Yes
	Eye redness	Yes		Joint swelling	Yes
	Photophobia	Yes		Myalgias	Yes
	Visual distrubance	Yes			
RESPIRATORY	Apnea	Yes	SKIN	Color change	Yes
	Chest tightness	Yes		Pallor	Yes
	Choking	Yes		Rash	Yes
	Cough	Yes		Wound	Yes
	Shortness of breath	Yes			
	Stridor	Yes			
	Wheezing	Yes			

Please turn to next page.....

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Neurological	Dizziness	Yes
	Facial asymmetry	Yes
	Headaches	Yes
	Light-headedness	Yes
	Numbness	Yes
	Seizures	Yes
	Speech difficulty	Yes
	Syncope	Yes
	Tremors	Yes
	Weakness	Yes
Hematologic	Adenopathy	Yes
	Bruises/bleed easy	Yes
Psychiatric	Agitation	Yes
	Behavior problem	Yes
	Confusion	Yes
	Decr concentration	Yes
	Dysphoric mood	Yes
	Hallucinations	Yes
	Hyperactive	Yes
	Nervous/Anxious	Yes
	Self -injury	Yes
	Sleep disturbance	Yes
	Suicidal ideas	Yes

Does your Neurosurgical problem affects your ability to work? _____YES _____NO

Please discribe the main reason for your visit:

_____

_____

_____

_____

_____

_____

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Pt Name: _____

CURRENT MEDICATION

(Please include all over-the-counter medications, herbal medications, and vitamins

Medication Name	Dosage	Route (oral, patch, injection, etc.)	Frequency (per day, week, or as needed

ALLERGIC REACTIONS

Are you allergic to any medications? If so, list the medication and the reaction you had.

Medication Name	Reaction (circle all that apply)
Example: Aspirin	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:

List all other drug/medication allergies and their reaction:

Other allergies

Have you had a reaction to any of the following?

YES NO Latex

YES NO Iodine

YES NO Intravenous contrast agent (used in CT scans)

List any other allergies:

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MEDICAL HISTORY: Please mark yes or no to any of these medical conditions for which you have been diagnosed:

Condition	YES	NO
Asthma		
Arrhythmia		
Angina		
Asthma		
Allergies		
Atrial fibrillation		
Autoimmune disease		
Bleeding disorder		
Cancer		
Chest pain		
Chronic bronchitis		
COPD (chronic obstructive pulmonary disease)		
Cirrhosis		
Clotting disorder		
CHF (congestive heart failure)		
Depression		
Diabetes		
Easy bruising		
Emphysema		
GERD (gastro-esophageal disease)		
Headaches		
Heart disease		
Heart murmer		

Condition	YES	NO
Heart valve problems		
Hepatitis - chronic		
HIV / AIDS		
Hypertension		
Kidney disease		
Liver disease		
Lung disease		
Melanoma		
Meningitis		
Myocardial infarction		
Nerve/muscle disease		
Other neurological disorders		
Palpitations		
Psychiatric treatment		
Pulmonary embolus		
Renal insufficiency		
Seizures		
Sickle cell anemia		
Sinus disorder		
Stroke		
Substance abuse		
Thyroid disease		
Ulcers		

SURGICAL HISTORY: Please mark "yes" for any of the below surgeries you have had and list approximate date of surgery:

Condition	YES	DATE
Appendectomy		
Brain surgery		
Breast surgery		
Cholecystectomy (removal of gallbladder)		
Colon surgery		
Coronary artery bypass surgery		
Gallbladder surgery		
Heart surgery		

Condition	YES	DATE
Hernia repair		
Hysterectomy		
Joint replacement		
Liver surgery		
Pancreas surgery		
Prostate surgery		
Spine surgery		
Thyroid surgery		

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Pt Name: _____

FAMILY HISTORY:

Please check the box for any of the family members that have had these medical concerns:

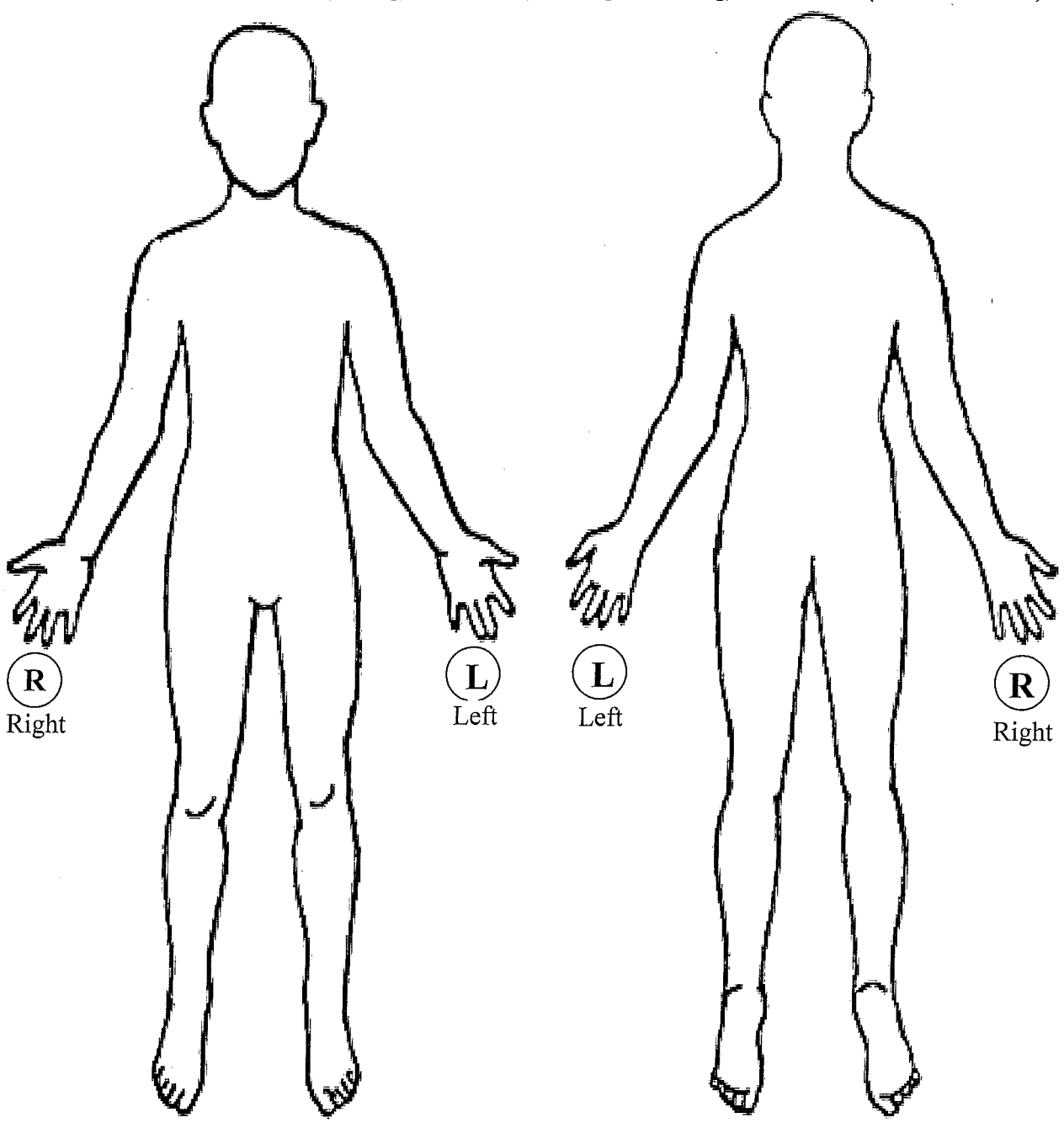
Family Member	Anesthesia Problems	Brain Cancer	Cancer	Clotting Disorder	High Blood Pressure	Stroke	Cardiac Stent	Heart Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

SOCIAL HISTORY:

Education	Less than grade school	Grade school	Middle school	High school	College graduate
Marital Status	Single	Married	Widowed	Divorced	Legally Separated
Do you live alone?	No	Yes			
Currently employed?	No	Yes	If yes, what is your occupation?		
Do you smoke cigarettes?	No	Yes	If yes, how many packs/day?	How long?	
Did you previously smoke cigarettes?	No	Yes	If yes, how many packs/day?	When did you quit?	
Do you drink alcoholic beverages?	No	Yes	If yes, how many drinks/day?	What kind?	
Do you use any of the following drugs?	cocaine	crack	LSD	marijuana	heroin other/recreational: _____
Have you used prescription medications more often than prescribed, or for a reason other than as prescribed?	No	Yes			
Is your visit today in relation to a lawsuit?	No	Yes			
Is this visit today in relation to a worker's comp claim?	No	Yes			

Use the following to indicate the location of where you are experiencing sensations in/on your body:

000 (Numbness) XXX (Aching) //// (Stabbing or Burning) +++ (Pins and Needles)



Please indicate your level of pain: 1 2 3 4 5 6 7 8 9 10

Provider to complete:

❑ Needs nutritional screen ❑ Patient education provided: _____

❑ Readiness to learn assessed ❑ Social work referral made _____

Vital Signs: BP_____ HR_____ Temp_____ RR_____ HT_____ WT_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____