David Schechter, M.D.
Review of Systems Form, New Patients

Name _____ , _____ _____Date _____
Last First Middle Month Day Year

Chief concern/reason for visit: _____ When began? _____

Other major concerns: _____

Other symptoms or areas of your body that are bothering you: (please circle)

NEURO:	headache—convulsions—seizures—fainting—A.D.D.—stroke__ Other:	NONE
PSYCHIATRIC:	depression—anxiety—stress/excess worry—drug/alcohol issues Other:	NONE
EYES:	Visual problem—Blurry Vision—Red Eyes Other:	NONE
NOSE:	nasal allergies—nose bleeds Other:	NONE
THROAT:	swallowing difficulty—frequent sore throats—speech problems Other:	NONE
MOUTH:	dental problems—tongue problems—canker sores Other:	NONE
NECK:	swollen glands—thyroid problems Other:	NONE
CHEST:	chest pain—asthma—shortness of breath—cough—TB Other:	NONE
HEART:	murmurs—palpitations—valve problems—mitral valve prolapse—angina Other:	NONE
INTESTINAL:	colitis—ulcer gastritis—Barrett's esophagus—polyps—constipation Other:	NONE
URINARY:	urinary problems—urinary frequency—burning—kidney stones Other:	NONE
GENITAL:	infection—warts—herpes—impotence—sexual difficulty Other:	NONE
UPPER EXTREMITY:	pain in arm— Carpal Tunnel—shoulder pain—elbow pain—wrist pain Other:	NONE
LOWER EXTREMITY	pain in legs—knee pain—hip pain—ankle pain—tingling Other:	NONE
SPINE:	low back pain—neck pain—mid back pain—scoliosis—herniated disc—sciatica Other:	NONE
SYSTEMIC:	weight loss—fever—night sweats—trouble sleeping—loss of energy—arthritis Other:	NONE

I smoke: _____ per day I drink _____ alcohol per week

ALLERGIES TO MEDICATIONS: (State drugs and their reactions) NONE

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SURGERIES: (list type of surgery, year performed or your age at the time of surgery) NONE

MEDICATIONS OR SUPPLEMENTS YOU TAKE REGULARLY (include dosage if you recall) NONE

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