David Schechter, M.D.
Review of Systems Form, *for physical exams*

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

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

_____

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

_____

David Schechter, M.D.

Review of Systems Form, Beverly Hills Office, *for complete physical exams*

PATIENT NAME _____

HOSPITALIZATIONS? (exclude above listed surgeries) NEVER

HOW MUCH DO YOU SMOKE PER **DAY**? _____ NONE

HOW MUCH ALCOHOL DO YOU DRINK PER **WEEK**? _____ NONE

HOW MANY CUPS OF CAFFEINE A DAY? (coffee, tea, soda w/ caffeine) NONE

WHAT ILLNESSES HAVE YOUR

PARENTS?_____
SIBLINGS?_____
GRANDPARENTS?_____
OTHER FAMILY MEMBERS?_____

SUFFERED FROM?

WHEN WAS YOUR LAST TETANUS SHOT? (If you remember) _____

WHEN WAS YOUR LAST FLU SHOT? _____

WHEN WAS YOUR LAST DENTAL EXAM? _____

WHEN WAS YOUR LAST EYE EXAM FOR GLAUCOMA? _____

WHEN WAS YOUR LAST MENSTRUAL PERIOD? _____ NOT APPLICABLE

HAVE YOU EVER HAD A COLONOSCOPY? _____

HOW OFTEN DO YOU EXERCISE IN A TYPICAL WEEK? _____

HOW MANY HOURS SLEEP IN A TYPICAL NIGHT? (any sleep difficulty?) _____

ANY OTHER HEALTH ISSUES NOT MENTIONED ABOVE?

_____

_____

_____

_____