David Schechter, M.D.
Review of Systems Form, *for new patients Side One*

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

_____

_____

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Review of Systems Form *for new patients*

PATIENT NAME _____ Date _____

HOSPITALIZATIONS? (exclude above listed surgeries) for: _____ NEVER

HOW MUCH TOBACCO DO YOU SMOKE PER **DAY**? _____ for how many years?_____ if ex- when? NONE

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

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

WHAT MAJOR DISEASES HAVE YOUR (e.g. Cancer, Heart Attack, Diabetes, High Blood Pressure, Stroke)

PARENTS? _____ and current age or age at death
SIBLINGS? _____ and current age or age at death
GRANDPARENTS? _____ and current age or age at death Had?
OTHER FAMILY MEMBERS? _____

WHEN WAS YOUR LAST TETANUS/PERTUSSIS SHOT? _____

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? _____ or NOT APPLICABLE

HAVE YOU EVER HAD A COLONOSCOPY? _____ When? Findings?

HOW OFTEN DO YOU EXERCISE IN A TYPICAL WEEK? _____ (Do what?)

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

ANY OTHER HEALTH ISSUES NOT MENTIONED ABOVE?

_____

_____

_____

_____

HAD COVID? APPROX DATES. _____

HAD COVID SHOTS? TYPE. BOOSTERS? _____ MOST RECENT BOOSTER_____

WHOM DO YOU LIVE WITH? _____ AGES OF CHILDREN, IF ANY?_____

OCCUPATION? _____