GFP 2025 DATE: _____

Review of Systems/Past Medical History

Please answer ALL the following questions

NAME: _____ DATE OF BIRTH: _____

What is your current marital status? ☐ Married ☐ Single ☐ Separated ☐Significant other ☐ Widowed

What is your current occupation/what do you do for a living? _____

Do you currently use tobacco/nicotine (smoking, vaping, chewing)? ☐ Yes ☐ No

If yes. Which do you currently use? _____ How often? _____

Are you a former smoker or formerly use tobacco/nicotine or marijuana (smoking, vaping, chewing)? ☐ Yes ☐ No

If yes. When did you quit? _____ What did you formerly use? _____

Do you currently use marijuana (smoking, vaping, edible, oil)? ☐ Yes ☐ No

Do you use any recreational drugs or any prescription medications that have not been prescribed to you? ☐ Yes ☐ No

If yes. What? _____

How many drinks of wine, beer or other alcoholic beverages do you have per week? ☐ None ☐1 ☐ 2-5 ☐ 6+

How many caffeinated drinks (coffee, soda, red bull, iced tea) do you drink a day? _____

Do you exercise for 20 minutes, three or more days per week? ☐ Yes ☐ Sometimes ☐ Never

If yes. What type of exercise? _____

Do you follow any specific diet (low sodium, low sugar)? ☐ Yes ☐ No

If so, which diet? _____

Experienced seizure/convulsions, dizziness, tremors, numbness or tingling or have recent head injury?

☐ Yes ☐ No If so, what? _____

Experienced frequent or recurring headaches? ☐ Yes ☐ No

If yes. How often? _____

Experienced an eye injury, blurred/double vision or been diagnosed with glaucoma? ☐ Yes ☐ No

If so, what and when? _____

Experienced hearing loss/ringing, earaches, chronic sinus problems, nose bleeds, mouth sores or bleeding gums, chronic sore throat, swollen glands in your neck or been diagnosed with speech or swallowing disorders?

☐ Yes ☐ No If so, what and when? _____

Experienced chest pains, irregular heartbeats (palpitations), shortness of breath, swelling in the ankles/feet or been diagnosed with high blood pressure, heart disease or vascular disease?

☐ Yes ☐ No If so, what and when? _____

Do you have a chronic cough/frequently cough, wheezing or been diagnosed with Asthma, COPD, or Sleep Apnea?

☐ Yes ☐ No If so, what? _____

Experienced loss of appetite, abdominal pains, rectal bleeding, changes in stool, nausea/vomiting or diagnosed with an ulcer or GI disorder?

☐ Yes ☐ No If so, what and when? _____

Any current or past experiences or diagnosis of insomnia, depression, and/or anxiety or other psychiatric issues?

☐ Yes ☐ No If yes. What type and when? _____

Do you experience incontinence (leaking of urine), frequent urination, blood in urine or diagnosed with kidney disease?

☐ Yes ☐ No If so, what? _____

Experienced joint/muscle pain, difficulty walking, balance issues, recent falls or diagnosed with Osteoarthritis?

☐ Yes ☐ No If so, what and when? _____

Experienced glandular/hormone changes, excessive thirst, or been diagnosed with Diabetes or a Thyroid disorder?

☐ Yes ☐ No If so, what? _____

 DATE: _____

Do you notice cuts are slow to heal or that you bruise or bleed easily or been diagnosed with Anemia, Hepatitis, or HIV?

☐ Yes ☐ No If so, please describe? _____

Any history of skin cancer, skin disorders, or any new or changing skin lesions? ☐ Yes ☐ No

If yes, year of cancer diagnosis? _____ Location of new skin lesions _____

Any current or past cancer diagnosis? ☐ Yes ☐ No

If yes. What type and when? _____

Any current or past diagnosis of autoimmune disorders such as Rheumatoid Arthritis or Lupus? ☐ Yes ☐ No

If yes. What type and when? _____

Please list any allergic reactions or bad reactions to any medications (antibiotics, iodine), food (gluten, shellfish), or materials (latex) and your reaction.

_____

_____

_____

Date of last and location of last mammogram: _____

Date and location of last eye exam: _____

Date and location of last dental visit: _____

Colon Cancer Screening: _____ Colonoscopy _____ Cologuard _____FOBT

Date it was done: _____ Where:_____

DATE: _____

Do you see any of the following specialties?

Cardiology	☐ Yes	☐ No	If yes, who/location: _____
Endocrinology	☐ Yes	☐ No	If yes, who/location: _____
Gynecology	☐ Yes	☐ No	If yes, who/location:_____
Nephrology	☐ Yes	☐ No	If yes, who/location: _____
Neurologist	☐ Yes	☐ No	If yes, who/location: _____
Ear/Nose/Throat	☐ Yes	☐ No	If yes, who/location: _____
Eye Doctor	☐ Yes	☐ No	If yes, who/location: _____
Dermatology	☐ Yes	☐ No	If yes, who/location: _____
Oncology	☐ Yes	☐ No	If yes, who/location: _____
Hematology	☐ Yes	☐ No	If yes, who/location: _____
Gastroenterology	☐ Yes	☐ No	If yes, who/location: _____
Pain Management	☐ Yes	☐ No	If yes, who/location: _____
Pulmonology	☐ Yes	☐ No	If yes, who/location: _____
Rheumatology	☐ Yes	☐ No	If yes, who/location: _____
Urology	☐ Yes	☐ No	If yes, who/location: _____
Naturopath	☐ Yes	☐ No	If yes, who/location: _____

Past surgical history—Please list the type, location, and year of all past surgeries.

_____

_____

_____

Family Medical History--- Please circle which of the following run in your family and which family member.

Cancer or Benign Tumors _____

Diabetes, Thyroid, Osteoporosis _____

Neurological (migraines, Stroke, MS) _____

Heart (heart failure/attacks, murmur, blood pressure) _____

Lung (COPD, Asthma) _____

Autoimmune Disorders (Rheumatoid Arthritis, Lupus) _____

Depression (bipolar, alcoholism) _____

DATE: _____

Please list any medications (including over the counter) you currently take and indicate which if any are prescribed by another provider.

Medication Name and Dosage	Prescribing Provider	How often do you take the medication?