Northeast Georgia PHYSICIANS GROUP

HISTORY AND REVIEW OF SYSTEMS

FRONT

Name: _____ DOB: _____ / _____ / _____ Today's Date: _____

Primary Care Physician: _____ Referring Physician: _____

What are we seeing you for today? _____

How long have you had this problem? _____ Telephone or location of your pharmacy: _____

CURRENT MEDICAL HISTORY: Please check (✓) all that apply:

- ❑ Abnormal Heart Rhythm
- ❑ Anemia
- ❑ Aneurysm
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer: TYPE_____
- ❑ Carotid Artery Disease
- ❑ Cirrhosis of the Liver
- ❑ COPD
- ❑ Colon Polyps
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes: ❑ Type I ❑ Type II
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Heart Attack
- ❑ Hiatal Hernia/GERD
- ❑ High Cholesterol
- ❑ High/Low Blood Pressure
- ❑ Implanted Device
- ❑ Kidney Disease/Stones
- ❑ Liver Disease
- ❑ Low Blood Sugar
- ❑ Pneumonia
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ TIA
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers

ALLERGIES: List all medication and/or food allergies and the type of reaction (Ex: Sulfa-rash, Codeine-nausea, etc.)

Allergy:	**Type of reaction:**
1.	
2.	
3.	
4.	
5.	

Are you allergic to latex? ❑ Yes ❑ No

Circle any of the following that you are currently taking on a regular basis:

Aspirin Arthritis medication Xarelto Eliquis Coumadin/Warfarin Other blood thinner

CURRENT MEDICATIONS: List all medications:

Medicine	Over-the-Counter Vitamins and Supplements	Dosage	How Often?	Provider
EX: Lasix		20 mg	Twice a day	Dr. Jones
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SURGICAL HISTORY:

Appendectomy – Date: _____
Back/Neck – Date: _____
Bariatric – Date: _____
Breast – Date: _____
Cardiac – Date: _____
Colon – Date: _____
Colonoscopy – Date: _____
Endoscopy – Date: _____
Gallbladder – Date: _____
Hernia Repair – Date: _____
Hysterectomy – Date: _____
Reflux – Date: _____
Thyroid – Date: _____
Other abdominal surgery: – Date: _____

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HISTORY AND REVIEW OF SYSTEMS

BACK

FAMILY HISTORY: Please check &/or list all family members that apply

Illness:	Relation to you (circle)					Alive	Deceased
Brain Aneurysm	Mother	Father	Sibling	Child	Other	❑	❑
Cancer	Mother	Father	Sibling	Child	Other	❑	❑
Diabetes	Mother	Father	Sibling	Child	Other	❑	❑
Heart Disease	Mother	Father	Sibling	Child	Other	❑	❑
Hypertension	Mother	Father	Sibling	Child	Other	❑	❑
Thyroid Problems	Mother	Father	Sibling	Child	Other	❑	❑
Stroke	Mother	Father	Sibling	Child	Other	❑	❑

SOCIAL HISTORY: Check &/or list all family members that apply:

Tobacco Use: ❑ Current / Former (Quit year _____) ❑ Never ❑ Exposure to smoke ❑ E-cigs ❑ Other: _____

Alcohol Use: ❑ Never drink ❑ Occasional drinker: _____ # drinks/day of alcohol

Drug Use: ❑ None ❑ Other use: _____

Caffeine Use: ❑ No ❑ Yes – how much: _____

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

children _____ # grandchildren _____

REVIEW OF SYSTEMS: Check all that you are *currently* experiencing:

General History:
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Increased Fatigue
- ❑ Trouble Sleeping
- ❑ Increased Appetite

Ear/Nose/Throat:
- ❑ Hoarseness
- ❑ Choking
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Sinus Drainage

Neurologic:
- ❑ Muscle Weakness
- ❑ Numbness
- ❑ Seizures
- ❑ Memory Loss/Dementia

Vascular:
- ❑ Mini-Strokes/TIAs
- ❑ Pain in legs when walking
- ❑ Cramping in legs

Gastrointestinal:
- ❑ Heartburn
- ❑ Regurgitation
- ❑ Difficulty Swallowing
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Bloating
- ❑ Early Feeling of Fullness
- ❑ Rectal Bleeding
- ❑ Constipation
- ❑ Diarrhea
- ❑ Change in Size/Color of stool
- ❑ # Bowel Movements/Day: _____

Respiratory:
- ❑ Difficulty Breathing
- ❑ Wheezing
- ❑ Cough: ❑ Mucous ❑ Blood

Cardiac:
- ❑ Chest Pains
- ❑ Palpitations
- ❑ Swollen Feet
- ❑ Shortness of Breath (when lying flat)
- ❑ Cardiac Cath:
  If yes, when: _____
- ❑ Cardiac Stress Test:
  If yes, when: _____

Breast (Female):
- ❑ Breast Mass
- ❑ Nipple Discharge:
  If yes, what color? _____
- ❑ Breast Pain/Tenderness
- ❑ Changes in Appearance
- ❑ Family History of Breast Cancer

OB/GYN (Female):
- ❑ Date of Last Period _____
- ❑ Age of Menstruation _____
- ❑ Menopause

Genitourinary:
- ❑ Difficulty Urinating
- ❑ Urinating Frequently at Night
- ❑ Blood in Urine
- ❑ Loss of Bladder Control
- ❑ Weak Stream

Endocrine:
- ❑ Glandular or Hormone Problem
- ❑ Thyroid Disease
- ❑ Excessive Thirst or Urination
- ❑ Heat or Cold Intolerance

Hematologic/Lymphatic:
- ❑ Slow to Heal After Cuts
- ❑ Easily Bruise or Bleed
- ❑ Anemia
- ❑ Phlebitis
- ❑ Past Transfusion
- ❑ Enlarged Glands

Allergic/Immunologic:
- ❑ History of Skin Reaction To: _____
- ❑ Penicillin or Other Antibiotics
- ❑ Morphine or Other Narcotics
- ❑ Novocaine or Other Anesthetics
- ❑ Tetanus or Other Serums
- ❑ Iodine or Other Antiseptic
- ❑ Known Food Allergies _____