Michael A. Ruchim, M.D.

Name: _____ Birthdate: _____ Today's Date: _____

Review of Systems

Please check if you've RECENTLY experienced the following:

Constitutional:

Fever? ☐ Weight Loss? ☐ Fatigue? ☐

Ears, Nose, Throat:

Sore Throat? ☐ Hoarsness? ☐ Ear Pain? ☐

Eyes:

Vision Disturbance? ☐ Eye Pain? ☐

Cardiovascular:

Chest Pain? ☐ Palpatations? ☐ Leg Cramps? ☐

Respiratory:

Shortness of Breath? ☐ Wheezing / Asthma? ☐ Cough? ☐

Gastrointestinal:

Vomiting? ☐ Trouble Swallowing? ☐ Heartburn? ☐ Change in bowel habits? ☐

Genitourinary:

Burning? ☐ Frequency? ☐

Musculoskeletal:

Muscle Tenderness? ☐ Weakness? ☐ New Bone Pain? ☐

Skin:

New Rashes? ☐

Neurologic:

Numbness / tingling? ☐ Dizziness? ☐ Seizures? ☐

Psychiatric:

Depression? ☐ Schizophrenia? ☐ Anxiety Disorder? ☐

Endocrine:

Thyroid Problems? ☐ Diabetes? ☐

Blood / Lymph:

Anemia? ☐ Enlarged Lymph glands? ☐

Allergy / Immunologic:

Allergic Asthma? ☐ Seasonal Allergies? ☐ Hives? ☐

Social History

Do you Smoke? Y / N If yes, how much? _____ packs per day

Drink Alcohol? Y / N If yes, how much? _____ per week

Significant Medical History in Primary Relatives

Mother: _____ Siblings: _____

Father: _____ Other: _____

Any family history of Colon Cancer or Polyps? Y / N **If so, in whom?** _____

Current Medications: _____

_____

_____

Medication Allergies: _____

Please list all previous medical problems or surgeries with dates (if known):

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____