

# C.A.R.E.S.

Charles D Manter DO PC

NAME: \_\_\_\_\_

\_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ # of Children – Ages \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REVIEW OF SYSTEMS

Have You Had problems with any of the following organs or organ systems?

	<u>YES</u>	<u>NO</u>	
HEAD:	___	___	Brain Aneurysm, Severe Headache, Other _____
EYES:	___	___	Glaucoma, Cataracts, Blurred Vision, Blindness, Other _____
EARS:	___	___	Deafness, Hearing loss, Vertigo, Ringing in Ears, Other _____
NOSE:	___	___	Sinus Infections, Nose Bleeds, Nasal Congestion, Other _____
THROAT:	___	___	Mouth Sores, Sore Throat, Sore Tongue, Other _____
CHEST:	___	___	COPD, Cough, Asthma, Emphysema, Pneumonia, TB, Other _____
HEART:	___	___	Heart Attack, Angina, Heart Failure, Heart Murmur, Other _____
ABDOMEN:	___	___	Liver Disease, Hepatitis, Pancreatitis, Gallstones, Other _____
GI:	___	___	Nausea, Reflux, Hiatal Hernia, Ulcer, Chronic Diarrhea, Other _____
URINARY:	___	___	Kidney Stones, Kidney Disease, Urethritis, Other _____
INFECTIONS	___	___	Aids, Hepatitis, Herpes, Other _____
SKELETAL	___	___	Arthritis, Pain in Joints, Pain in Muscles, Other _____
HEMATOL:	___	___	Bleeding Disorder, Swollen Glands (lymph nodes), Other _____
SKIN:	___	___	Skin Cancer, Seborrhea, Psoriasis, Other _____
VASCULAR:	___	___	High Blood Pressure, Blood Clots, Emboli, High Cholesterol, Other _____
ENDOCRIN:	___	___	Diabetes, Thyroid Disease, Pituitary Disease, Other Hormonal Problems _____
NEURO:	___	___	Stroke, Numbness, Tremor, Seizures, Dizziness, Other _____
PSYCH:	___	___	Psychological Disease, _____

**CANCER** \_\_\_\_\_ Date \_\_\_\_\_ Type \_\_\_\_\_ Remission \_\_\_ Y \_\_\_ N  
\_\_\_\_\_ Date \_\_\_\_\_ Type \_\_\_\_\_ Remission \_\_\_ Y \_\_\_ N

## HABITS

Smoke \_\_\_\_\_ #Pks/day \_\_\_\_\_ How Long? \_\_\_\_\_  
Coffee/Caffeine \_\_\_\_\_ What? \_\_\_\_\_ How Much \_\_\_\_\_  
Alcohol? \_\_\_\_\_ What? \_\_\_\_\_ How Much? \_\_\_\_\_  
Drug Abuse \_\_\_\_\_ What? \_\_\_\_\_

## SURGICAL HISTORY

	Date	Surgery	Date	Surgery
SURGERY	_____	_____	_____	_____
SURGERY	_____	_____	_____	_____

## FAMILY HISTORY

	Age	Medical Problems (If Deceased, put age and cause of death)
FATHER	_____	_____
MOTHER	_____	_____
CHILDREN	_____	_____
	_____	_____
	_____	_____