MALE REVIEW OF SYSTEMS

(1) Please let us know who your doctors are.

REFERRING PHYSICIAN:_____

FAMILY PHYSICIAN:_____

OTHER PHYSICIANS TO RECEIVE COPIES OF REPORTS:

_____

DENTIST:_____

(2) Your name:_____

(3) Date of Birth_____Age_____

(4) Vital signs (for nurse only):

Ht_____ Wt_____ BP_____

T_____ P_____ R_____

(5) Consultation Date _____

(6) Please check any of the following medical problems that you have or have ever had:

___ Connective tissue disease (lupus, scleroderma, rheumatoid arthritis)
___ Skin cancer
___ Other cancer
___ Heart attack/ Heart problems/ Pacemaker
___ High blood pressure
___ Diabetes
___ Emphysema
___ Asthma
___ Epilepsy (seizures)
___ Ulcer
____ Liver disease (cirrhosis)
____ Gallbladder disease
____ Intestinal disease (colitis, diverticulitis, chronic diarrhea)
____ Kidney problems (kidney stones, kidney failure)
____ Arthritis
____ Thyroid problems
____ Tuberculosis
____ HIV positive
____ Hepatitis

Other_____

(7) Please list all previous surgeries (e.g. tonsillectomy, appendix, hernia, cesarean section, etc.).

Date:	Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(8) Please list any other hospitalizations for serious illness or injury.

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____

(9) Have you ever received radiation therapy in the past (including as a child for acne or thyroid disease)? ☐ Yes ☐ No

If yes, please tell us:

A. Which part of the body was treated?_____

B. Approximate dates of treatment:_____

C. Name of facility where treatment was given:_____

(10) Have you ever had chemotherapy? ☐ Yes ☐ No

If yes, please tell us:

A. Name of the physician who gave you this treatment: _____

B. Approximate date of last chemotherapy:_____

(11) **Please list** all prescribed medications you are currently taking. (Please include over-the-counter medications such as aspirin, Tylenol, antacids, vitamins, herbs, etc.)

Name:	Dosage:	How often:	Used for:

(12) Are you allergic to any medications, to tape or to latex? ☐ Yes ☐ No

If yes, please list them below, including reaction.

_____

_____

(13) Are you allergic to: X-ray dyes? ☐ Yes ☐ No

Shellfish? ☐ Yes ☐ No

Have you previously received X-ray dyes? ☐ Yes ☐ No

Please list preferred pharmacy and location _____

I give consent to look up prescription history if needed **Initial here** _____

(14) Have any of your blood relatives been diagnosed with cancer? ☐ Yes ☐ No

If yes, please list.

Relative	Type of cancer
_____	_____
_____	_____
_____	_____

(15) SOCIAL HISTORY

Please circle one: Single Married Widowed Divorced

Children:	Age	Gender	Age	Gender
	_____	M F	_____	M F
	_____	M F	_____	M F

Who lives with you at home now?_____

Did you ever work outside the home? ☐ Yes ☐ No

If yes, what is/was your occupation?_____

If you are retired, please tell us when you stopped working?_____

(16) HABITS

A. Have you ever used tobacco? ☐ Yes ☐ No

If yes, please circle all that apply: cigarettes cigars pipe snuff

How much?_____ How many years? _____

Have you quit? ☐ Yes ☐ No

If yes, when did you quit?_____

B. Has there ever been a period in your life during which you drank alcohol excessively? ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes ☐ No

If yes, what type and how frequently?_____

C. Any illegal (non-physician prescribed) drug use?_____

(17) NUTRITION

A. Have you had an unintentional weight loss of greater than 8 pounds? ☐ Yes ☐ No

B. Problems eating? ☐ Yes ☐ No

What kind of problems?_____

C. Problems swallowing? ☐ Yes ☐ No

(18) SYMPTOM REVIEW

General Condition

Can you climb one flight of stairs without being short of breath? ☐ Yes ☐ No

How far can you walk on level ground without feeling short of breath?_____

Do you require assistance to carry out your normal daily chores? ☐ Yes ☐ No

Are you using any community services at this time? ☐ Yes ☐ No

Which of the following services are you using: ☐ Meals on wheels ☐ Elder care

☐ Transportation ☐ Long term care ☐ Other_____

Please let us know if you have or have had any of the following complaints: (Check the appropriate column. *"Recently"* means within the last three months.)

	Recently	Previously	Details
Weight loss	_____	_____	_____
Loss of appetite	_____	_____	_____
Fever/chills	_____	_____	_____
Excessive sweating	_____	_____	_____
Extreme tiredness	_____	_____	_____
Severe headaches	_____	_____	_____
Vision problems	_____	_____	_____
Dizziness	_____	_____	_____
Loss of consciousness	_____	_____	_____
Seizures	_____	_____	_____
Weakness/paralysis(arm or leg)	_____	_____	_____
Numbness/tingling	_____	_____	_____
Hearing problems	_____	_____	_____
Sinus problems	_____	_____	_____
Nose problems	_____	_____	_____
Sore throat	_____	_____	_____
Difficult/painful swallowing	_____	_____	_____
Hoarseness	_____	_____	_____

	Recently	Previously	Details
Ear Pain	_____	_____	_____
Difficulty breathing	_____	_____	_____
Cough	_____	_____	_____
Wheezing	_____	_____	_____
Coughing up blood	_____	_____	_____
Chest pain	_____	_____	_____
Leg swelling	_____	_____	_____
Nausea/vomiting	_____	_____	_____
Indigestion/heartburn	_____	_____	_____
Pain in abdomen	_____	_____	_____
Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Blood in stool	_____	_____	_____
Difficulty holding stool	_____	_____	_____
Burning on urination	_____	_____	_____
Blood in urine	_____	_____	_____
Increased frequency of urination	_____	_____	_____
Difficulty holding urine	_____	_____	_____
Joint pain	_____	_____	_____
Bone pain	_____	_____	_____
Skin rash	_____	_____	_____
Lumps in the body	_____	_____	_____
Changes in your mood/depression	_____	_____	_____
Change in your sleep habits	_____	_____	_____

How many times per night do you awaken to urinate? _____

Do you have difficulty starting urination? ☐ Yes ☐ No

How often do you urinate during the day? Every _____ hours

Have you noticed any change in your ability to have erections? ☐ Yes ☐ No

(19) Is there any other medical information that you feel we should know?

_____

_____

_____

(20) Do you have a Living Will? ☐ Yes ☐ No

Medical Power of Attorney? ☐ Yes ☐ No

Do you have an Out-of-Hospital Do-Not-Resuscitate Directive? ☐ Yes ☐ No

(If yes, please provide a copy of these directives for our records)

If not, would you like to speak to someone about these directives? ☐ Yes ☐ No