

**Review of Systems**

4501 Medical Center Drive #200 McKinney Tx. 75069

Michael J. Parisi, D.O.

Jill Saad, PA-C

Patient Name \_\_\_\_\_

DATE \_\_\_\_\_

Describe the reason for your visit today \_\_\_\_\_

Please list your medications (include vitamins, supplements and over the counter medicine)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use oxygen? Yes No Do you use CPAP or BIPAP? Yes No  
When was your last Tetanus shot? \_\_\_\_\_ Pneumonia shot? \_\_\_\_\_

List Any Known Drug Allergies. What reaction did you have?

\_\_\_\_\_  
\_\_\_\_\_

Please mark any of the following symptoms that apply to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Nasal congestion         | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Urinary frequency         |
| <input type="checkbox"/> Runny nose               | <input type="checkbox"/> Chills                 | <input type="checkbox"/> Urinary incontinence      |
| <input type="checkbox"/> Sneezing                 | <input type="checkbox"/> Sweats                 | <input type="checkbox"/> Blood in urine            |
| <input type="checkbox"/> Sore throat              | <input type="checkbox"/> Weight loss            | <input type="checkbox"/> Burning on urination      |
| <input type="checkbox"/> Itchy eyes               | <input type="checkbox"/> Weight gain            | <input type="checkbox"/> Vaginal Discharge         |
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Irregular menstrual cycle |
| <input type="checkbox"/> Dizziness/Vertigo        | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Sexual problems           |
| <input type="checkbox"/> Ear Drainage             | <input type="checkbox"/> Vomiting               | <input type="checkbox"/> Seizure                   |
| <input type="checkbox"/> Ear pressure/Ear pain    | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Loss of consciousness     |
| <input type="checkbox"/> Swollen lymph nodes      | <input type="checkbox"/> Constipation           |  |
| <input type="checkbox"/> Cough Productive? Yes No | <input type="checkbox"/> Heartburn/reflux       |  |
| <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Change in bowel habits |  |
| <input type="checkbox"/> Wheezing                 | <input type="checkbox"/> Blood in stool         |  |
|   | <input type="checkbox"/> Abdominal pain         |  |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Joint Pain             |  |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Joint Swelling         |  |
| <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Joint Stiffness        |  |
| <input type="checkbox"/> Memory loss              | <input type="checkbox"/> Rash                   |  |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Dry skin               |  |
| <input type="checkbox"/> Palpitations             |   |  |

Do you have any other symptoms or medical problems not listed above? Please be specific.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ Mammogram? \_\_\_\_\_ PSA? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been diagnosed with any of the following Ailments? Please mark the box if you currently have, or have ever been treated for the conditions below. What year were you diagnosed?

- | Yes   | Year  |   |
|-------|-------|---|
| _____ | _____ | Arthritis OsteoArthritis Rheumatoid arthritis |
| _____ | _____ | Asthma  |
| _____ | _____ | Anxiety                                       |
| _____ | _____ | Atrial fibrillation                           |
| _____ | _____ | Arrythmia (Abnormal heart rythm)              |
| _____ | _____ | Blood clot in the lung                        |
| _____ | _____ | Blood clot in the leg                         |
| _____ | _____ | Blood in the urinc                            |
| _____ | _____ | Blood transfusion Why? _____                  |
| _____ | _____ | Blood in stool                                |
| _____ | _____ | Cataracts                                     |
| _____ | _____ | Colou polyp                                   |
| _____ | _____ | Coronary artcry disease (Heart Disease)       |
| _____ | _____ | Congestive heart Failure                      |
| _____ | _____ | Blocked Carotid arteries (Neck arteries)      |
| _____ | _____ | COPD/Emphysema                                |
| _____ | _____ | Dementia                                      |
| _____ | _____ | Depression                                    |
| _____ | _____ | Diabetes mellitus Do you take insulin? YES NO |
| _____ | _____ | Diverticulosis/Diverticulitis                 |
| _____ | _____ | Enlarged prostate                             |
| _____ | _____ | Fibromyalgia                                  |
| _____ | _____ | GERD (Acid Reflux/Heartburn)                  |
| _____ | _____ | Gout  |
| _____ | _____ | Glaucoma                                      |
| _____ | _____ | Hcmorrhoids                                   |
| _____ | _____ | Heart murmur Mitral Valve Prolapsc? _____     |
| _____ | _____ | Hepatitis A--Hepatitis B--Hepatitis C         |
| _____ | _____ | Hepatitis unknown type                        |
| _____ | _____ | High blood pressure                           |
| _____ | _____ | Kidney stones                                 |
| _____ | _____ | Liver problems                                |
| _____ | _____ | Osteoporosis                                  |
| _____ | _____ | Peripheral vascular disease                   |
| _____ | _____ | Stroke  |
| _____ | _____ | TIA (mini stroke)                             |
| _____ | _____ | Thyroid problems High? Low? Goiter?           |
| _____ | _____ | Tuberculosis                                  |
| _____ | _____ | Uleer, stomach or duodena!                    |
| _____ | _____ | Urinary tract infections -- Recurrent?        |

**Cancer**

- |       |                               |                                       |
|-------|-------------------------------|---------------------------------------|
| _____ | Bladder                       | What treatment did you receive? _____ |
| _____ | Breast                        | _____                                 |
| _____ | Colon                         | _____                                 |
| _____ | Cervix/Uterus                 | _____                                 |
| _____ | Lung                          |                                       |
| _____ | Melanoma                      | What Year? _____                      |
| _____ | Other skin cancer             |                                       |
| _____ | Prostate                      |                                       |
| _____ | Other site Please be specific | _____                                 |

Do you have any other known medical problems? Please specify: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Social/Family/Hospitalization History

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### Social History

Yes No Do you smoke? Cigarettes-pipe-cigars How much? \_\_\_\_\_ Years? \_\_\_\_\_ Quit? \_\_\_\_\_  
 Yes No Do you chew Tobacco or dip Snuff?  
 Yes No Do you drink Alcohol? How Much? \_\_\_\_\_ How often? \_\_\_\_\_  
 Yes No Do you drink caffeine? How many cups per day? \_\_\_\_\_  
 Yes No Have you ever used street drugs? What Drugs? \_\_\_\_\_  
 When did you last use them? \_\_\_\_\_  
 Yes No Do you have tattoos, or multiple body piercings?  
 Yes No Do you work? Occupation \_\_\_\_\_  
 Yes No Are you disabled? Why? Be specific: \_\_\_\_\_  
 Are you Married? Divorced? Widowed? Widower? Please circle answer.

Please indicate positive family history by writing **YES** in the appropriate box below.

Family History	Mother	Father	Siblings	Children	Grand parents
Asthma					
Lung disease					
Cancer (Specify type)					
Chemical dependency					
Depression Mental illness					
Diabetes					
Heart disease Heart attack					
High blood pressure					
Kidney disease					
Kidney stones					
Osteoarthritis					
Rheumatoid arthritis					
Stroke					
Tuberculosis					
Deceased?					
Cause of death?					

Other family medical history:

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Have you ever been hospitalized? Why? Where?

Year	Reason for hospitalization	Hospital location
Year	Number of pregnancies?	Any complications?

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Print your name \_\_\_\_\_

### Past Surgical History

4501 Medical Center Drive #200, McKinney, TX, 75069

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Have you had any of the following procedures performed? Please answer yes or no. If yes please indicate the year. Tell us where the procedure was performed. What were the results?

			YEAR
YES	NO	Stress Test	_____
YES	NO	Heart catheterization	_____
YES	NO	Angioplasty	_____
YES	NO	Coronary stent placement	_____
YES	NO	Bronchoscopy	_____
YES	NO	Colonoscopy	_____
YES	NO	Echocardiogram (ultrasound of the heart)	_____
YES	NO	Colposcopy	_____
Yes	NO	Pacemaker or Defibrillator placement	_____
YES	NO	Flexible sigmoidoscopy	_____
YES	NO	Upper GI endoscopy	_____
YES	NO	Ultrasound of Carotid arteries (Neck)	_____
YES	NO	Cat scan or MRI -- Why and what part of your body?	_____

YES	NO	Dialysis
YES	NO	Bone density test

Surgical History      ( ) I have never had surgery

			YEAR	
YES	NO	Appendectomy	_____	
YES	NO	Amputation	_____	Location _____
YES	NO	Aneurysm Repair	_____	Location _____
YES	NO	Bladder surgery	_____	
YES	NO	Breast Augmentation	_____	
YES	NO	Breast Biopsy	_____	
YES	NO	Mastectomy	_____	
YES	NO	Back surgery	_____	Type _____
YES	NO	Neck surgery	_____	Type _____
YES	NO	Carpal tunnel --right--left	_____	
YES	NO	C-Section	_____	
YES	NO	Cataract --right--left	_____	
YES	NO	Carotid artery	_____	
YES	NO	Colon resection	_____	
YES	NO	Colostomy	_____	
YES	NO	Coronary Bypass (heart)	_____	How many Vessels? _____
YES	NO	D & C	_____	
YES	NO	Endometrial Bopsy	_____	
YES	NO	Gall Bladder removed	_____	
YES	NO	Hernia	_____	Location _____
YES	NO	Hemorrhoidectomy	_____	
YES	NO	Hip replacement --right--left	_____	
YES	NO	Hip fracture repair	_____	
YES	NO	Hysterectomy	_____	
YES	NO	Knee arthroscopy	_____	
YES	NO	Knee replacement --right--left	_____	
YES	NO	Lung Surgery	_____	Be specific _____
YES	NO	Peripheral Vascular	_____	
YES	NO	Sinus Surgery	_____	
YES	NO	Tonsils or Adenoids	_____	
YES	NO	Tube Tied	_____	
YES	NO	Vasectomy	_____	
YES	NO	Biopsy an other site	_____	

Any Other Surgery?

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_