Alliance Behavioral Medicine, LLC
Review of Systems/Medical History Update

Patient Name_____ Date of Birth_____
Date_____ Chart Number_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

General
Good general health lately ..... no yes
Recent weight change ..... no yes
Fever ..... no yes
Fatigue ..... no yes

Eyes and vision
Eye disease or injury ..... no yes
Blurred or double vision ..... no yes
Glaucoma ..... no yes

Ears, nose, throat and mouth
Hearing loss ..... no yes
Ringing in the ears ..... no yes
Earaches ..... no yes
Sinus problems ..... no yes
Mouth sores ..... no yes
Dental or chewing problems ..... no yes
Dentures ..... no yes

Heart trouble
Heart trouble ..... no yes
Chest pains ..... no yes
Sudden heartbeat changes ..... no yes
Swelling of feet, ankles, hands ..... no yes

Breathing trouble
Frequent coughing ..... no yes
Spitting up blood ..... no yes
Shortness of breath ..... no yes
Asthma or wheezing ..... no yes

Stomach trouble
Loss of appetite ..... no yes
Change in bowel movements ..... no yes
Nausea or vomiting ..... no yes
Stomach pain ..... no yes
Gastric Bypass or Lap Band ..... no yes

Joint trouble
Cold hands/feet ..... no yes
Difficulty walking ..... no yes
Muscle pain or cramps ..... no yes

Neurologic trouble
Frequent or recurrent headaches ..... no yes
Light headed or dizzy ..... no yes
Convulsions or seizures ..... no yes
Numbness or tingling sensations ..... no yes
Tremors or shaking ..... no yes
Involuntary movements ..... no yes
Stroke ..... no yes
Head injury ..... no yes
Balance problems ..... no yes

Hormone trouble
Thyroid disease ..... no yes
Diabetes ..... no yes
Excessive thirst or urination ..... no yes
Heat or cold intolerance ..... no yes
Change in hat or glove size ..... no yes
Change in skin color ..... no yes
Change in hair or nails ..... no yes

Bleeding trouble
Slow to heal after cuts ..... no yes
Easily bruising or bleeding ..... no yes
Anemia ..... no yes

Urination trouble
Frequent urination ..... no yes
Burning or painful urination ..... no yes
Blood in urine ..... no yes

ACTIVITY: (CHECK ONE OR MORE BOXES)
□ Occasional vigorous activity.
□ Regular vigorous exercise.

WOMEN:
Last menstrual period? _____
Any menstrual problems? Yes_____ No_____
Number of pregnancies _____
Difficult pregnancy? Yes_____ No_____
Miscarriages? _____
Birth control method (if any)? _____
Hysterectomy? Yes_____ No_____
Breast pain/lump/discharge? Yes_____ No_____
Last mammogram? _____
Reviewed By_____Date_____

MEN:
Prostate problems? Yes_____ No_____
Erectile problems? Yes_____ No_____
Vasectomy? Yes_____ No_____
Hormone Irregularities? Yes_____ No_____

Patient/Guardian Signature_____Date_____