Complete Care Center
Medical History & Review of Systems (ROS)

In order to provide for your health needs concerning your medical care, we would like you to answer the following questions. This information will become a part of your confidential medical record. If you do not understand our questions place a "?" alongside. PLEASE PRINT. Thank you.

Patient's Name _____ Age _____ Medical Record # _____ Today's Date _____

Do you have a **Durable Power of Attorney:** Yes No If no, are you interested in receiving information about a **Durable Power of Attorney?** Yes No

Chief Complaint: _____

HEALTH HISTORY

Previous Surgeries/Physicians/ Hospitalizations — Year

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Do you smoke? No ___ Yes ___ Pk/day _____ # of Years ___
When did you quit _____
Do you use marijuana? No ___ Yes ___ How often? _____
Do you use illicit (street) drugs? No ___ Yes ___ Specify _____
Do you drink alcohol? No ___ Yes ___ How many years? _____
How many days per week? _____ How much? _____
History of blood transfusions? No ___ Yes ___
Caffeine Use? No _____ Yes ____ Exercise? No _____ Yes ____

GENERAL INFORMATION

Place a check if you have the following:

____ Upper plate dentures
____ Lower plate dentures
____ Partial plate dentures
____ Bridge
____ Loose teeth or caps
____ Artificial eye
____ Contact lens
____ Eye glasses
____ Hearing aid
____ Pacemaker
____ Artificial limbs

FAMILY HISTORY

Check if your mother, father, sisters or brothers have had any of the following:

____ High Blood Pressure
____ High Blood Sugar (Diabetes)
____ High Cholesterol
____ Heart Trouble
____ Stroke
____ Cancer and Type
____ Asthma
____ Arthritis
____ Thyroid Problems
_____
_____
_____

MEDICATIONS

List medications you are taking:

_____
_____
_____
_____

ALLERGY

List medications, food, pets, latex environment, Lidocaine, Betadine,

_____
_____
_____

HERBAL SUPPLEMENTS

_____
_____
_____

VITAMINS

_____
_____
_____

Would any religious belief influence your medical decisions if you became really sick? Yes No

Do you have any spiritual needs that you would like someone to address? Yes No

Review of Systems

Do you have or have you had any of the following: (ROS 15)

Yes	No		Yes	No	
___	___	Abnormal EKG	___	___	Frequent or severe headaches
___	___	Heart trouble or Rheumatic Fever	___	___	Loss of bowel or bladder control
___	___	High blood pressure	___	___	Memory loss
___	___	Pain or tightness in chest	___	___	Muscle weakness or numbness in extremities
___	___	Rapid Heart or missed beat	___	___	Problems with sleep
___	___	Swollen feet or ankles	___	___	Seizures or convulsions
___	___	Use 2 pillows or more to sleep to assist with breathing	___	___	Unconsciousness or blackout
___	___	Weight loss or gain within last 2 years	___	___	Cancer
___	___	High Cholesterol	___	___	Stroke history
___	___	High or low blood sugar	___	___	TB
___	___	Thyroid or goiter problems (heat/cold intolerance)	___	___	History of depression or anxiety
___	___	Chronic Sinus Infection	___	___	Asthma/Wheezing
___	___	Recent hoarseness lasting longer than 2 weeks	___	___	Chronic lung problems/Emphysema
___	___	Glaucoma or vision problems	___	___	Chronic or frequent cough
___	___	Bloody urine or pain on urination	___	___	Shortness of Breath
___	___	Prostate Problems	___	___	Shortness of breath with activity
___	___	Up at night to urinate	**Women's Section**		
___	___	Bloody or black stools	___	___	Are you post menopausal?
___	___	Bowel problems or change in habits (diarrhea/constipation)	___	___	# of live births _____
___	___	Digestive or stomach problems (nausea/vomiting/heartburn)	___	___	Complication with Pregnancy
___	___	Kidney problem or stone	___	___	Age of first menses (period) _____
___	___	Liver problems or jaundice	___	___	Last normal menstrual period _____
___	___	Anemia or blood problems	___	___	Have you ever had an abnormal pap smear?
___	___	Easy bruising or bleeding from gums or nose	___	___	Bleeding or spotting between periods
___	___	Do you have any rashes or itching?	___	___	Excessive bleeding with periods
___	___	Do you have any skin color changes?	___	___	Are you pregnant?
___	___	Arthritis, painful, swollen joints	___	___	Date of last PAP and pelvic exam _____
___	___	Back trouble or problem lifting 20lbs	___	___	Date of last mammogram _____
___	___	Fracture or broken bones			
___	___	Do you have dizzy spells			
___	___	Do you have fainting spells			

This information is given to the best of my knowledge. _____ Reviewed by Dr./CNP: _____
Patient Signature

Review Date: _____