



ADULT DATABASE / REVIEW OF SYSTEMS

Name: _____ Age: _____ Date: _____

Occupation: _____ Birth Date: _____ Single Separated Widow
 Married Divorced

Arizona Resident Since: _____ Birth Place: _____

List all persons who live in your household: None

Name	Relation	Birth Year
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Surgeries: (Type and Year) None

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations: (other than surgeries and childbirth) None

For what reason	Month / Year
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Accidents: No Injuries of consequence

Injury cause	Date / Age
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Medications taken frequently: (dose / time per day) None

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies to Medication: (Name of Medication/Reaction) None

1. _____
2. _____
3. _____
4. _____
5. _____

Habits: None

Alcohol Yes No
 How many _____ day/wk/mo
 Liquor _____ drinks per _____ for _____ years _____
 Beer _____ drinks per _____ for _____ years _____
 Wine _____ drinks per _____ for _____ years _____

Tobacco Yes No
 Cigarettes _____ packs per day _____ for _____ years
 Vape _____ Other _____

Recreational Drug use Yes No Past Current
 Types _____ Frequency _____

Females only: Obstetrical History None

Number of pregnancies _____
 Full term pregnancies _____ Vaginal _____ Caesarean _____
 Premature Deliveries _____
 Abortions _____ Miscarriage _____
 Did you have: Gestational Diabetes Yes No
 Pre-eclampsia Yes No
 High Blood Pressure Yes No

Family History: (any significant family medical history)

MEDICAL POWER OF ATTORNEY Yes No Name: _____

LIVING WILL Yes No Date: _____

Please Turn Over.....

Patient Name: _____

Previous Doctor: _____

Recent Travel: None

Out of country travel in the last 2 years? Yes No

Where / When? _____

Past Illness: None

Serious past illness Yes No

Date/Age: _____

Sexually Transmitted Disease Yes No

Gonorrhea Chlamydia HIV/AIDS

Herpes Syphilis Other _____

Review of symptoms: Please check all that apply

Head & Neck Yes No Yes No

Headaches Ringing in ears

Vision/Glasses Pain in ears

Falling Vision Ear Discharge

Eye Pain Repeated nosebleeds

Double Vision Teeth Problems

See "floating lights" Frequent colds

Severe hearing loss Nose obstruction

Chronic sore throat Persistent sore gums

Prolonged neck rigidity Swelling in neck

Gastrointestinal Yes No Yes No

Chronic abdominal pain Persistent Nausea

Heartburn Appetite loss

Vomit blood Yellowing of skin

Chronic diarrhea Black tarry stools

Bleeding from rectum Gray stools

Chronic constipation Hemorrhoids

OB/GYN (Women Only) Yes No Yes No

Age menstruation started _____ Any missed periods

Average cycle length _____ Excess menstruation

Last menstrual period _____ Painful menstruation

Bleed between cycles

Neuro/Psychological Yes No Yes No

Depression Paralysis/weakness

Therapy/counseling Nervous breakdown

Mental health problem Personality changes

Dizzy spells Memory loss

Speech disturbance Marital problems

Drug Abuse Alcohol Abuse

Immunizations: Yes No None

MMR (measles, mumps, rubella) Date _____

Tdap (tetanus, diphtheria, pertussis) Date _____

Hep A and Hep B (Hepatitis) Date _____

Shingles Date _____

Chicken Pox Date _____

Influenza (flu) Date _____

Tetanus Date _____

Pneumococcus Date _____

Other: _____

Cardiovascular Yes No Yes No

Heart Problems Hypertension

Chest pain on effort Skipping/Irregular

Ankle swelling heartbeat

Difficulty breathing

Pulmonary Yes No Yes No

Chronic cough Spit up blood

Frequent chest colds Wheezing

Night sweats Difficulty breathing when

lying down

Urinary Yes No Yes No

Frequent urination Difficulty urinating

Scanty urination Blood in urine

Frequent night urination Pain with urination

Leakage of urine Passed any stones

Bedwetting Retention of urine

Musculoskeletal Yes No Yes No

Physically handicapped _____ Tingling sensations

or limited Muscle/Joint issues

Shoulder pain Back pain

Issues walking Muscle jerking

Paralysis Shaking

Strokes Seizures

Additional Concerns

Provider Notes

