CARRBORO FAMILY MEDICINE CENTER, P.A.
Patient Centered. Community Based.

Carrboro Family Medicine Center, P.A.
610 Jones Ferry Road, Suite 102
Carrboro, North Carolina 27510
Telephone: 919-929-1747 • Fax 919-933-5168
www.carrborofamilymedicine.net

Review of Systems

Name: _____ Medical Provider: _____

Date: _____ Chart # _____

Please list any changes in your family history _____

List any major changes in your health or procedures done _____

YES	NO	
		GENERAL:
_____		Date of last Tetanus shot
___	___	List any known allergies _____
___	___	Do you smoke? How many packs per day? _____
___	___	Do you use other forms of tobacco or electronic cigarettes? Which ones? _____
___	___	If you use tobacco, are you ready to quit?
___	___	Do you drink alcohol? How many drinks? _____ per day, or _____ per week, of what? _____
___	___	Do you drink caffeine? How many drinks per day? _____ What beverage(s)? _____
___	___	Do you use illicit or recreational drugs? Which ones and how often? _____
___	___	Follow a low cholesterol diet?
___	___	Fever
___	___	Fatigue
___	___	Change in weight
___	___	Loss of appetite
___	___	Exercise: How man minutes each time, and how man da s/week? (e.g., 40 mins 4 days/wk) _____
		SKIN: **(Comments to Be Completed By Provider)**
___	___	Skin problems
___	___	New skin lesions or unusual/changed moles Rash
		HEAD, EYES, EARS, NOSE, THROAT:
___	___	Nasal congestion
___	___	Runny nose
___	___	Chronic sore throat
_____		Date of last dental exam
_____		Date of last eye exam
___	___	Eye/Vision problems
___	___	Hearing difficulty
		NECK:
___	___	Swollen glands
		RESPIRATORY:
___	___	Shortness of breath
___	___	Wheezing
___	___	Chronic cough
		BREAST:
___	___	Monthly self breast exam
___	___	Breast mass
___	___	Breast pain
___	___	Nipple discharge
___	___	Skin changes
		CARDIOVASCULAR:
___	___	Chest pain or tightness
___	___	Edema or swollen ankles
___	___	Wake up suffocating
___	___	Palpitations or irregular heart rhythm

PLEASE CONTINUE ON THE BACK OF THIS FORM.

YES	NO	GASTROINTESTINAL:	(Comments to Be Completed By Provider)
___	___	Abdominal pain	
___	___	Frequent Heartburn	
___	___	Nausea or Vomiting	
___	___	Diarrhea	
___	___	Constipation	
___	___	Blood in stool or black stool	
___	___	Difficulty swallowing	
_____		Date of last colonoscopy	
___	___	Hemorrhoids	

		FEMALE GENITOURINARY:	MALE GENITOURINARY:	YES	NO
___	___	Painful urination	Urination problems or painful	____	____
___	___	Pink/red urine	Pink/red urine	____	____
___	___	Incontinence of urine	# urinations at night	____	____
_____		Date of last bone density	Sexual problems	____	____
_____		Date of last mammogram	Testicular pain/nodules	____	____
___	___	Date of last PAP	Monthly testicular exam	____	____
___	___	History of abnormal PAP	Penile discharge	____	____
___	___	Sex painful or problems	Worried about sexual diseases	____	____
___	___	Menstrual problems/irregularity	Birth control method	_____	
_____		Form of contraception			
___	___	Vaginal discharge			
___	___	Worried about sexual diseases			
_____		Date of last menstrual period			

		MUSCULOSKELETAL:
___	___	Back pain
___	___	Joint pain
___	___	Joint swelling Muscle pain Neck pain

		NEUROLOGICAL:
___	___	Numbness or tingling
___	___	Weakness in extremities
___	___	Dizziness or fainting
___	___	Frequent or severe headaches

		PSYCHIATRIC:
___	___	Anxiety or Nervousness
___	___	Depression
___	___	Insomnia or change in sleep Irritability

		ENDOCRINE:
___	___	Cold intolerance
___	___	Hair loss or changes
___	___	Heat intolerance
___	___	Hot flashes
___	___	Decreased libido

		HEMATOLOGY:
___	___	Enlarged lymph nodes

Current Medications, Herbs or Supplements: _____

_____

_____

Seeing any Specialists (indicate name and reason):_____

_____

_____