Central Park Medical Associates
Review of Systems, Past Medical, Family and Social History Form

GENERAL

Fever	O Yes	O No
Weight Loss / Gain	O Yes	O No
Extreme Fatigue	O Yes	O No
Night sweats	O Yes	O No

ENDOCRINOLOGY

Excessive thirst	O Yes	O No
Insomnia	O Yes	O No

LUNGS/RESPIRATORY

Shortness of breath	O Yes	O No

CARDIOLOGY

Chest pain	O Yes	O No
Palpitations	O Yes	O No
Ankle swelling	O Yes	O No
Pacemaker	O Yes	O No

PSYCHOLOGY

Depression	O Yes	O No
Suicidal ideation	O Yes	O No
Anxiety	O Yes	O No

MUSCULOSKELETAL

Joint pain	O Yes	O No
Back pain	O Yes	O No

Ear/Nose/Throat

Nose bleed	O Yes	O No
Ringing in ears	O Yes	O No
Difficulty swallowing	O Yes	O No

NEUROLOGY

Headache	O Yes	O No
Tingling/Numbness	O Yes	O No
Seizures	O Yes	O No

Eyes

Irritation of the Eyes/ Eyelids	O Yes	O No
Blurred Vision	O Yes	O No

GASTROENTEROLOGY

Diarrhea	O Yes	O No
Constipation	O Yes	O No
Eating Problems	O Yes	O No

HEMATOLOGY/LYMPH

Bleeding	O Yes	O No
Sweating	O Yes	O No
Swollen glands	O Yes	O No

Urinary

Difficulty urinating	O Yes	O No
Frequency	O Yes	O No
Burning	O Yes	O No

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Allergy/Immunology

Dust	O Yes	O No		
Ragweed	O Yes	O No		
Molds	O Yes	O No		
Pollen	O Yes	O No		

Skin

Itchiness	O Yes	O No		
Skin Allergies	O Yes	O No		
Hair loss	O Yes	O No		
Lumps/Growths	O Yes	O No		
Rashes	O Yes	O No		
Changing-Moles/Lesions	O Yes	O No		

Pregnancy Issues

Currently Pregnant	O Yes	O No		
Currently Breast feeding	O Yes	O No		
Currently on birth control	O Yes	O No		

Social History

Smoker	O Yes	O No		
	O > 1 pack/day	O < 1 pack/day		
Alcohol	O Yes	O No		
	O Daily	O Weekly	O Monthly	O Yearly
Recreational drug use	O Yes	O No		
Sexually active	O Yes	O No		
Lives alone	O Yes	O No		
Regular exercise	O Yes	O No		
Regularly uses sunscreen	O Yes	O No		
Tanning bed use	O Yes	O No		
At least 1 blistering sunburn	O Yes	O No		

Past Medical History

History of skin cancer	O Yes	O No		
Skin Cancer Type	O N/A	O Basal Cell	O Squamous Cell	
	O Melanoma	O Other		
Skin disease	O Yes	O No		

Family History

Family history of Skin Cancer	O Yes	O No		
Mother	O Yes	O No		
Father	O Yes	O No		
Family history of Skin Disease	O Yes	O No		
Mother	O Yes	O No		
Father	O Yes	O No		

Name: _____ Signature: _____ Date: _____