Bowie Internal Medicine Associates
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The following information is very important to your health. Please take a moment to complete both sides of this form.

Name: _____ Date of Birth:_____

Chief complaint: What is your most serious problem or reason for your visit today?

Review of systems: Please check any of the following that you are currently or have recently experienced.

1) General
( ) Fatigue (feeling tired) or drowsiness
Excessive gain ( ) or loss of weight ( )
( ) Chills ( )Fevers ( ) Night sweats
( ) Swollen glands

2) Head/Eye/Ear/Nose Throat
Problems or pain with ( ) ears ( ) nose ( ) throat ( ) sinuses
Persistent sore mouth ( ) or tongue ( )
Eye pain ( ) Visual problems/blurred vision ( ) Double vision ( )
( ) Runny nose ( ) Nose bleeds ( ) Hoarseness ( ) Difficulty swallowing

3) Skin
Change in hair ( ) Change in nails ( ) Change in skin ( ) _____
( ) Persistent lumps or sores _____
( ) Change in moles _____
( ) Rashes or lesions _____
( ) Bruising ( ) Hives ( ) Itching

4) Endocrine
Intolerance to ( ) heat or ( ) cold
( ) Excessive thirst
( ) Excessive hunger

5) Lungs
( ) Chronic cough Bringing up blood ( ) or phlegm ( )?
( ) Wheezing or asthma ( ) Snoring
( ) Hay fever or allergy symptoms
( ) Shortness of breath When? _____

6) Cardiovascular
( ) Shortness of breath with walking upstairs
( ) Shortness of breath waking you at night
( ) Passing out or fainting
( ) Chest pain or pressure
( ) Irregular or rapid heartbeat ( ) Feel heart beating/pounding (Palpitations)

Swelling of ( ) feet/ankles ( ) hands ( ) face/eyes
Coldness/paleness of ( ) hands or ( ) feet
Leg cramps when you walk around ( ) or at night ( )

7) Musculoskeletal
( ) Neck pain ( ) Back Pain
( ) Pain in joints or muscles? Where? _____
( ) Redness or warmth in joints ( ) Swelling or joints ( ) Limited movement of joints

8) Stomach/Intestines
( ) Decreased appetite ( ) Increased appetite
( ) Abdominal pain or discomfort
( ) Nausea ( ) Vomiting ( ) Belching
( ) Food sticking with swallowing
( ) Food intolerance What kinds? _____
( ) Hemorrhoids ( ) Bleeding from rectum
Stools: ( ) bloody ( ) black or tarry ( ) loose ( ) pale or clay-colored ( ) diarrhea ( ) constipation

9) Neurological
( ) Weakness
( ) Abnormal sensations or pains? Where? _____
( ) Persistent trembling or shaking
( ) Frequent or severe headaches
( ) Dizziness or vertigo
( ) Trouble falling or staying asleep (insomnia)

10) Genitourinary
Urination: ( ) painful ( ) frequent ( ) slow/weak stream ( ) urgency/difficulty delaying
( ) Getting up at night to urinate How many times on average? _____
( ) Blood in the urine ( ) Weak or absent control of urine? When? _____

11) Reproductive
( ) Sexual difficulty or dysfunction ( ) Pain with intercourse
( ) Testicular pain/swelling/lump
Menstruation: ( ) heavy ( ) painful ( ) irregular or bleeding between cycles
( ) Post-menopausal bleeding
( ) Breast changes or lumps ( ) Nipple changes or discharge ( ) Breast pain
Vaginal symptoms: ( ) pain ( ) itching/burning ( ) discharge color? _____

12) Behavioral
( ) Feeling sad or tearful
( ) Loss of interest in usual activities/hobbies
( ) Excessive nervousness or worrying
( ) Memory loss-difficulty remembering things

The above information is true, correct and complete to the best of my belief/

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Signature:_____ Date:_____

Reviewed by: _____ __/__/__