Has anyone in your family been treated for the conditions listed or other medical problems?

Diabetes ❑ Yes ❑ No
Seizures ❑ Yes ❑ No
Other
High Blood Pressure ❑ Yes ❑ No
Heart Problems ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If yes, how many per day

Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how many

Do you now, or have you ever had any of the following conditions? Please circle yes or no and provide any additional information.

REVIEW OF SYSTEMS (Have you ever had or do you now have any of the conditions listed?) Yes or no.

I. SKIN

Itching ❑ Yes ❑ No
Rash ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Pigmentations ❑ Yes ❑ No
Lack or loss of body hair ❑ Yes ❑ No

II. EXTREMITIES

Varicose veins ❑ Yes ❑ No
Swollen, painful joints ❑ Yes ❑ No
Muscle weakness, pain ❑ Yes ❑ No
Bone deformity, fracture ❑ Yes ❑ No
Prosthetic joints (hip, knee...) ❑ Yes ❑ No

III. EYES

Blurring of vision ❑ Yes ❑ No
Double vision ❑ Yes ❑ No
Drooping of eyelid ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No

IV. EAR, NOSE, THROAT

Earache ❑ Yes ❑ No
Hearing loss ❑ Yes ❑ No
Frequent nosebleeds ❑ Yes ❑ No
Sinusitis ❑ Yes ❑ No
Frequent sore throat ❑ Yes ❑ No
Hoarseness ❑ Yes ❑ No

V. RESPIRATORY

Cough, blood in sputum ❑ Yes ❑ No
Bronchitis, Emphysema ❑ Yes ❑ No
Wheezing, Asthma ❑ Yes ❑ No
Tuberculosis, Exposure to ❑ Yes ❑ No

VI. CARDIAC

Shortness of breath ❑ Yes ❑ No
Pain, pressure in chest ❑ Yes ❑ No
Heart attack ❑ Yes ❑ No
Swelling of ankles ❑ Yes ❑ No
High, low blood pressure ❑ Yes ❑ No
Rheumatic, Scarlet fever ❑ Yes ❑ No
Heart murmur/Mitral Valve Prolapse ❑ Yes ❑ No
Prosthetic valves/Pacemakers ❑ Yes ❑ No

VII. GASTROINTESTINAL

Difficulty swallowing ❑ Yes ❑ No
Abdominal pain, ulcers ❑ Yes ❑ No
Jaundice, Hepatitis ❑ Yes ❑ No
Liver disease ❑ Yes ❑ No

VIII. GENITOURINARY

Difficulty, Pain of urination ❑ Yes ❑ No
Blood in urine ❑ Yes ❑ No
Excessive urination ❑ Yes ❑ No
Kidney problems ❑ Yes ❑ No
Sexually transmitted diseases ❑ Yes ❑ No

IX. ENDOCRINE

Thyroid trouble ❑ Yes ❑ No
Weight change ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Excessive thirst ❑ Yes ❑ No

X. HEMATOPOIETIC

Easy bruising, excessive bleeding ❑ Yes ❑ No
Persistent swollen lymph nodes ❑ Yes ❑ No
Anemia ❑ Yes ❑ No
HIV infection, AIDS ❑ Yes ❑ No
Leukemia, problems with immune system ❑ Yes ❑ No
Spleen problems ❑ Yes ❑ No

XI. NEUROLOGIC

Frequent headaches ❑ Yes ❑ No
Epilepsy, Fits ❑ Yes ❑ No
Neuritis, Neuralgia ❑ Yes ❑ No
Parasthesias, Numbness ❑ Yes ❑ No
Paralysis ❑ Yes ❑ No

XII. PSYCHIATRIC

Nervousness, Irritability ❑ Yes ❑ No
Anxiety ❑ Yes ❑ No
Depression ❑ Yes ❑ No
Nervous breakdown ❑ Yes ❑ No

XIII. GROWTH OR TUMOR

Radiotherapy ❑ Yes ❑ No
Chemotherapy ❑ Yes ❑ No

Any other medical conditions

To the best of my knowledge, this form has been completed accurately. I/we hereby authorize Dr. Robb's office to complete all agreed upon services for myself/my child. I understand that I am responsible for the fees for the services performed. I understand that habitual broken appointments might result in an office charge.

Date: Signature:

(Patient or parent if minor)