

 **Cheshire Medical Center**
Dartmouth-Hitchcock Keene
590 Court Street, Keene, NH 03431 tel. (603) 354-5400

Date: _____

Patient Name: _____

DOB: _____

Occupation: _____

Illness/Surgeries: _____ Year: _____

Married Divorced Single Widowed

Chief Complaint: _____

Family History: _____ Relation: _____

Cancer _____

Polyps _____

Ulcer _____

Liver Disease _____

Pancreatitis _____

Note any illnesses, if deceased, give age and cause of death:

Father _____

Mother _____

Brothers _____

Sisters _____

Spouse _____

Children _____

Do you smoke? Yes No

#Packages per day _____

#of years smoked _____

Do you use alcohol? Yes No

#of drinks per week _____

Medicines:
(list all prescriptions, over-the-counter drugs, vitamins, etc.)

Allergies:

Drug: _____

Other: _____

Reviewed by: _____

REVIEW OF SYSTEMS

Constitutional

Recent weight change Yes No
Fever Yes No
Fatigue Yes No

Eyes

Blurred vision Yes No
Glaucoma Yes No

Ears/Nose/Mouth/Throat

Hearing loss Yes No
Ringing in ears Yes No
Mouth sores Yes No

Cardiovascular

Chest pain Yes No
Shortness of breath Yes No
Swelling of ankles Yes No

Respiratory

Chronic cough Yes No
Spitting up blood Yes No
Wheezing Yes No

Genitourinary

Burning urination Yes No
Blood in urine Yes No

Musculoskeletal

Joint pain or swelling Yes No
Back pain Yes No
Muscle pain Yes No

Skin

Rash Yes No
Itching Yes No

Comments:

Gastrointestinal

Poor appetite Yes No
Difficulty in Swallowing Yes No
Heartburn Yes No
Nausea or Vomiting Yes No
Bloating Yes No
Belching Yes No
Regurgitation Yes No
Constipation Yes No
Diarrhea Yes No
Abdominal pain Yes No
Recent change in bowel habits Yes No
Rectal bleeding Yes No
Black, tarry stools Yes No

Neurological

Headaches Yes No
Seizures Yes No
Strokes Yes No
Numbness Yes No

Psychiatric

Memory loss or confusion Yes No
Depression Yes No

Endocrine

Heat or cold intolerance Yes No
Excessive thirst or urination Yes No

Hematological

Bleeding or bruising tendency Yes No
Anemia Yes No
Past transfusion Yes No

Are you pregnant Yes No

Reviewed:	
Date _____	By _____
Date _____	By _____
Date _____	By _____