Cheshire Medical Center
Dartmouth-Hitchcock Keene

590 Court Street, Keene, NH 03431 tel. (603) 354-5400

Date: _____

DOB: _____

Occupation: _____

☐ 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 _____

Patient Name: _____

Illness/Surgeries: Year:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medicines:

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

_____

_____

_____

_____

_____

_____

Allergies:

Drug:_____

Other: _____

_____

Reviewed by: _____

OVER PLEASE

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_____