



Cheshire Medical Center

Dartmouth-Hitchcock

580 Court Street, Keene, NH 03431 603-354-5400

Date: _____

DOB: _____

Occupation: _____

Married Divorced Single Widowed

Chief Complaint: _____

Family History:

Relation:

Colon Cancer _____

Pancreatic Cancer _____

Colon Polyps _____

Ulcer _____

Liver Disease _____

Pancreatitis _____

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

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Children _____

Patient Name: _____

Surgeries: _____ Year: _____

Adverse Reaction to sedation/anesthesia? Y N

What was the Reaction? _____

Do you smoke? Yes No

Packs per day _____

of years smoked _____

Do you use alcohol? Yes No

of drinks per week _____

Drug Use? Yes No

Drug(s) Used _____

Clean Since _____

Please review the other side of this form. Thank you!

Review of Systems

Constitutional:

Fatigue	Yes	No
Recent weight gain	Yes	No
Recent weight loss	Yes	No

Eyes:

Eye pain	Yes	No
Loss of vision	Yes	No

ENT:

Ringing in the ears	Yes	No
Mouth sores	Yes	No
Dentures	Upper	Lower

Heart:

Chest pain with exertion	Yes	No
Palpitations	Yes	No
Swelling of the ankles	Yes	No

Lungs:

Shortness of Breath	Yes	No
Wheezing	Yes	No
Chronic cough	Yes	No

Gastrointestinal:

Abdominal pain	Yes	No
If yes, where?	_____	
Bloating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Vomiting blood	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Bright red rectal bleeding	Yes	No
Black tarry stools	Yes	No
Heartburn	Yes	No
Difficulty swallowing	Yes	No
Painful swallowing	Yes	No
Loss of appetite	Yes	No
Jaundice	Yes	No

Kidneys/Bladder:

Burning with urination	Yes	No
Blood in the urine	Yes	No

Musculoskeletal:

Joint pain	Yes	No
If yes, where?	_____	
Back pain		

Skin:

New skin lesions	Yes	No
Itching	Yes	No

Neurological:

Headaches	Yes	No
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Psychiatric:

Anxiety	Yes	No
Depression	Yes	No
Suicidal Thoughts	Yes	No

Hematological:

Easy bleeding	Yes	No
Easy bruising	Yes	No

Other: