

CoreHealth of Clearwater LLC
1501 S. Missouri Ave.
Clearwater, FL 33756
727-216-3216

Patient Name: _____

Date of Birth: _____

Review of Systems

In the past 6 months which of the following have you suffered from?

Circle all that apply

General:

Normal Allergies Fatigue Weakness Fever Chills Loss of Sleep Weight Change
Night Sweats Colds

Other: _____

Skin

Normal Cold Sores Hives Fever Blisters Rash Redness Itching Dryness Eczema
Hair Changes Nail Changes Bruise Easily

Other: _____

Neurologic

Normal Headache Dizziness Fainting Convulsions Nervousness Numbness

Other: _____

Eyes

Normal Vision Trouble Glaucoma Pain Discharge

Other: _____

Ears

Normal Hearing Trouble Ringing Pain Discharge

Other: _____

Musculoskeletal

Normal Arthritis Bursitis Disc Herniation Swelling Gout Sprain/Strain Tendonitis

Other: _____

Nose

Normal Pain Bleeding Sinus Problems Polyps Infections Absence of Smell

Other: _____

CoreHealth of Clearwater LLC
1501 S. Missouri Ave.
Clearwater, FL 33756
727-216-3216

Patient Name: _____

Date of Birth: _____

Mouth/Throat

Normal Sores Bleeding Enlarged Glands Absence of Taste Abnormal Taste Tonsillitis

Other: _____

Cardiovascular-Pulmonary (Heart and Lung)

Normal Cough Wheezing Difficulty Breathing Varicose Veins Murmurs Chest Pain

Palpitations Swollen Legs/Feet/Arms/Wrists Redness/Blueness of Hands/Feet

Other: _____

Breasts

Normal Lumps in Breast/s Redness/Itching Pain Dimpling Discharge

Other: _____

Gastrointestinal (Stomach/Digestion)

Normal Appendicitis Chron's Disease Colitis Ulcers Diverticulitis Diverticulosis

Increased Appetite Decreased Appetite Gallbladder Trouble Abdominal Pain

Excessive Gas Vomiting Diarrhea Constipation Hemorrhoids

Other: _____

Genitourinary

Normal Frequent Urination Painful Urination Inability to Hold Urine Bedwetting

Impotence Sterility Prostate Problems Blood in Urine Irregular/Painful Menstruation

Abnormal Vaginal Bleeding

Other: _____

Endocrine

Normal Intolerance to Heat or Cold Eyebrow Loss Weight Gain/Loss Diabetes Goiter

Other: _____

Psychologic

Normal Anxiety Depression Memory Loss/Impairment Phobias Mood Swings

Other: _____

CoreHealth of Clearwater LLC
1501 S. Missouri Ave.
Clearwater, FL 33756
727-216-3216

Patient Name: _____

Date of Birth: _____

What are your hobbies?

- | | | | |
|----------|--------------|------------|------------|
| 1. _____ | Occasionally | Frequently | Constantly |
| 2. _____ | Occasionally | Frequently | Constantly |
| 3. _____ | Occasionally | Frequently | Constantly |

What are your habits?

Smoking:	Never	Occasionally	Frequently	Constantly
Alcohol:	Never	Occasionally	Frequently	Constantly
Coffee/Tea:	Never	Occasionally	Frequently	Constantly
Soda:	Never	Occasionally	Frequently	Constantly
Exercise:	Never	Occasionally	Frequently	Constantly
Drug/Substances:	Never	Occasionally	Frequently	Constantly