FIRSTMED-FMC KFT.
Hattyúház, Budapest

**Name**:_____

# Review of systems

Please fill out the following questionnaire to the best of your knowledge. Please indicate any symptoms you have had in the past years. This will help us serve you in a more efficient and more professional way. Thank you for choosing FirstMed Centers!

**Please fill out all pages!**

| | Yes | No |
|---|---|---|
| **General** | | |
| *Have you noticed any* | | |
| Change in weight | ☐ | ☐ |
| Change in appetite | ☐ | ☐ |
| Change in thirst | ☐ | ☐ |
| Change in exercise tolerance | ☐ | ☐ |
| Change in voice | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Night sweats | ☐ | ☐ |
| General weakness | ☐ | ☐ |
| Malaise | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Heat intolerance | ☐ | ☐ |
| Cold intolerance | ☐ | ☐ |
| Bleeding tendencies | ☐ | ☐ |
| **Skin** | | |
| *Have you noticed any* | | |
| Rash | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Moles | ☐ | ☐ |
| Skin tumors | ☐ | ☐ |
| Change in hair | ☐ | ☐ |
| Change in nails | ☐ | ☐ |
| Easy bruising | ☐ | ☐ |
| **Eyes** | | |
| *Have you ever noticed any* | | |
| Change in vision | ☐ | ☐ |
| Double vision | ☐ | ☐ |
| Excessive tearing | ☐ | ☐ |
| Eye pain | ☐ | ☐ |
| Eye redness | ☐ | ☐ |
| Eye discharge | ☐ | ☐ |
| **Ears** | | |
| *Have you noticed any*: | | |
| Ear discharge | ☐ | ☐ |
| Ear pain | ☐ | ☐ |
| Ringing in ears | ☐ | ☐ |
| Change in hearing | ☐ | ☐ |
| **Nose** | | |
| *Have you noticed any* | | |
| Nasal discharge | ☐ | ☐ |
| Nasal congestion | ☐ | ☐ |
| Postnasal drip | ☐ | ☐ |
| Frequent nosebleeds | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| **Mouth and throat** | | |
| *Have you noticed any* | | |
| Oral or tongue sores | ☐ | ☐ |
| Frequent sore throat | ☐ | ☐ |
| Toothache | ☐ | ☐ |
| Gum bleeding | ☐ | ☐ |
| Problem with swallowing | ☐ | ☐ |
| Dry mouth | ☐ | ☐ |
| **Neck** | | |
| *Have you noticed any* | | |
| Lumps in your neck | ☐ | ☐ |
| Goiter | ☐ | ☐ |
| Swollen glands | ☐ | ☐ |
| **Breasts** | | |
| *Have you noticed any* | | |
| Breast lumps | ☐ | ☐ |
| Discharge from breast | ☐ | ☐ |
| Pain in breast | ☐ | ☐ |
| Breast tenderness | ☐ | ☐ |
| **Respiratory** | | |
| *Have you noticed any* | | |
| Cough | ☐ | ☐ |
| Sputum production | ☐ | ☐ |
| Coughing up blood | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Chest pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Exposure to person(s) with Tuberculosis | ☐ | ☐ |
| **Cardiovascular** | | |
| *Have you ever noticed any* | | |
| Palpitations | ☐ | ☐ |
| Swelling of legs | ☐ | ☐ |
| Pain in legs while walking | ☐ | ☐ |
| Loss of hair on legs | ☐ | ☐ |
| Varicose veins | ☐ | ☐ |
| Coolness of extremity | ☐ | ☐ |
| Discoloration of extremity | ☐ | ☐ |
| Leg ulcer | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| **GI** | | |
| *Have you noticed any* | | |
| Heartburn | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Change in bowel habits | ☐ | ☐ |
| Abnormal stool color or Consistency | ☐ | ☐ |
| Blood in stool | ☐ | ☐ |
| Rectal pain | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ |
| Excessive belching | ☐ | ☐ |
| Food intolerance | ☐ | ☐ |
| **Urinary:** | | |
| *Have you noted any* | | |
| Frequent urination | ☐ | ☐ |
| Urgency to urinate | ☐ | ☐ |
| Pain or burning during or after urination | ☐ | ☐ |
| Difficulty in initiating or maintaining urine stream | ☐ | ☐ |
| Excessive urination | ☐ | ☐ |
| Decreased urination | ☐ | ☐ |
| Incontinence | ☐ | ☐ |
| Awakening at night to urinate | ☐ | ☐ |
| Change in urine color | ☐ | ☐ |
| Change in urine odor | ☐ | ☐ |
| Change in urine volume | ☐ | ☐ |
| Flank pain | ☐ | ☐ |
| **Male genitalia:** | | |
| *Have you noticed* | | |
| Urethral discharge | ☐ | ☐ |
| Lesion on penis | ☐ | ☐ |
| Scrotal masses | ☐ | ☐ |
| Inguinal masses or pain | ☐ | ☐ |
| Pain in genitalia | ☐ | ☐ |
| Recent change in libido | ☐ | ☐ |
| Impotence | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| **Female genitalia:** | | |
| *Have you noted any* | | |
| Lesions of genitalia | ☐ | ☐ |
| Vaginal itching | ☐ | ☐ |
| Vaginal discharge | ☐ | ☐ |
| Pain with intercourse | ☐ | ☐ |
| Irregularity of periods | ☐ | ☐ |
| Excessive menstrual blood loss | ☐ | ☐ |
| Bleeding between periods | ☐ | ☐ |
| Hot flashes | ☐ | ☐ |
| Postmenopausal bleeding | ☐ | ☐ |
| Change in libido | ☐ | ☐ |
| **Musculoskeletal:** | | |
| *Have you noted any* | | |
| Muscle pain | ☐ | ☐ |
| Muscle cramps | ☐ | ☐ |
| Muscle stiffness | ☐ | ☐ |
| Joint pain | ☐ | ☐ |
| Joint stiffness | ☐ | ☐ |
| Back pain | ☐ | ☐ |
| Neck pain | ☐ | ☐ |
| Limitation of movement | ☐ | ☐ |
| Deformities | ☐ | ☐ |
| **Neurologic:** | | |
| *Have you noted any* | | |
| Headache | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Muscle weakness | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Tremor | ☐ | ☐ |
| Problem with coordination (walking or writing or dressing ) | ☐ | ☐ |
| Problem with speech | ☐ | ☐ |
| Loss of memory | ☐ | ☐ |
| Mood changes | ☐ | ☐ |
| Nervousness | ☐ | ☐ |
| Hallucination | ☐ | ☐ |
| Disorientation | ☐ | ☐ |
| Anxiety (panic attacks) | ☐ | ☐ |
| Trouble with concentration | ☐ | ☐ |
| Sleeplessness | ☐ | ☐ |

**Name**:_____

# History

**Past medical history:**
Please list any serious illnesses you ever had:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list all surgeries or other hospitalizations:

_____ _____ _____
_____ _____ _____

**Gynecological history (for Women Only):**

Last menstrual period:_____

Number of pregnancies:_____

Number of child deliveries:_____

Number of miscarriages:_____

Number of abortions:_____

Last mammogram:_____

Last pap smear:_____

History of abnormal pap smear:_____

Planning to become pregnant in near future Yes No

**Immunization History:**
Please indicate the date for your last tetanus vaccination_____

Have you ever had FSME (tick borne encephalitis) vaccination? _____

Have you ever had Hepatitis A vaccination?_____

Have you ever had Hepatitis B vaccination?_____

**Social History:**

Marital status:_____

Children:_____

Occupation:_____

Nutrition:_____

Exercise:_____

Tobacco use:_____

Alcohol/recreational drug use:_____

Sexual behavior

| | | |
|---|---|---|
| Monogamous | Yes | No |
| Uses condom | Yes | No |
| Uses contraception | Yes | No |

**Family history:**

Please list any significant illnesses that your family members listed below suffering or suffered from (e.g. Cancer, diabetes, hypertension, heart disease, stroke, seizure, dementia, etc.)

Mother:_____

Father:_____

Maternal grandmother:_____

Maternal grandfather:_____

Paternal grandmother:_____

Paternal grandfather:_____

Siblings:_____

Children:_____

**Medications:**

Please list all prescription **or** over-the-counter medicines you take:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Allergies:**

Please list all allergies (drug, food, etc.):

_____ _____ _____
_____ _____ _____

**Please describe below your main reason for this visit:**

Please indicate your preference for **preliminary follow-up** contact by FirstMed Centers:

| | |
|---|---|
| | Email – work: |
| | Email – home: |
| | Daytime phone #: |
| | Evening phone #: |

Please indicate your preference for receiving your **formal reports**:

| | | |
|---|---|---|
| | Local postal address: | |
| | Collect in person: | |