



# DEER PARK FAMILY DOCTORS Visit Information

Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/06

What is the **ONE most important reason** you need to see the doctor today?

Have you been treated by any **Other Doctors**, been diagnosed with any **New Illnesses**, been in the **Hospital or Emergency Room**, or had any **Operations or Surgeries** since we saw you last?

Have there been any **Changes** in your Medicines?    Yes    No    **Please bring your medicines to each visit!**

If you smoke **Cigarettes: Packs** a day? \_\_\_\_\_    **Years** smoking? \_\_\_\_\_

Do you need:    **School / Work** excuse    /    **Referral** for Insurance Company    /    **Forms** filled out

**Review of Systems: circle ONLY THOSE that apply to TODAY'S problem**

**General**

Fatigue / Appetite Loss  
Chills / Fevers / Sweats  
Weight Loss / Gain  
Intolerance to Cold / Heat

**No Problems**

**Eyes**

Blurring / Double Vision  
Itching / Watering / Pain  
Discharge / Irritation  
Light Sensitivity  
Vision Loss

**No Problems**

**Ears/Nose/Throat**

Decreased Hearing  
Earache  
Ringing In The Ears  
Seasonal Allergies  
Nasal Congestion  
Difficulty Swallowing  
Hoarseness  
Sore Throat

**No Problems**

**Heart**

Near Fainting / Fainting  
Chest Pain or Discomfort  
Breathlessness Lying  
Down / with Exertion  
Racing / Skipping Beats  
Swelling / Leg Cramps

**No Problems**

**Lungs**

Cough / Excessive Sputum  
Coughing Up Blood  
Snoring / Breathing Pauses  
Shortness of Breath  
Wheezing

**No Problems**

**GI / Bowels**

Indigestion / Gas / Pain  
Nausea / Vomiting  
Vomiting Blood  
Constipation / Diarrhea  
Bloody / Tarry Stools  
Hemorrhoids

**No Problems**

**Urine**

Frequency / Urgency  
Foul Discharge  
Painful Urination  
Blood In Urine  
Inability to Control Bladder  
Difficulty Urinating  
Night Time Urination

**No Problems**

**Male / Female**

Heavy / Missed Periods  
Pelvic Pain  
Genital Sores  
Problems With Sexual  
Drive / Orgasm /  
Erections

**No Problems**

**Musculoskeletal**

Joint Pain / Swelling  
Back Pain  
Muscle Aches / Cramps

**No Problems**

**Skin**

Itching / Rash / Hives  
Suspicious Lesions  
Hair / Nail Changes

**No Problems**

**Nerves / Neurological**

Memory Loss  
Headaches  
Seizures / Fainting  
Balance / Falls / Dizzy  
Weakness / Tremors  
Numbness / Tingling

**No Problems**

**Psychiatric**

Anxiety / Depression  
Sense Of Danger  
Thoughts of Suicide  
Thoughts of Violence

**No Problems**

**Other**

Bruising / Bleeding  
Enlarged Lymph Nodes  
HIV Exposure

**Details / Other:** Use this space to add anything else that would help us care for you today

**MD Signature:**

