NAME: _____ Date of Birth _____

Please briefly describe your symptoms

_____

_____

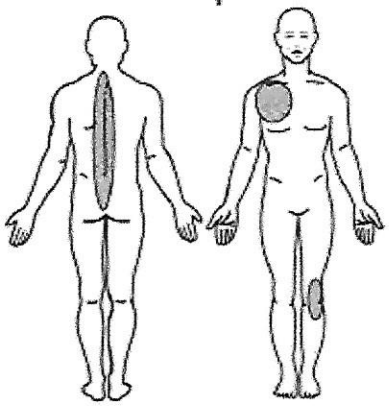
_____

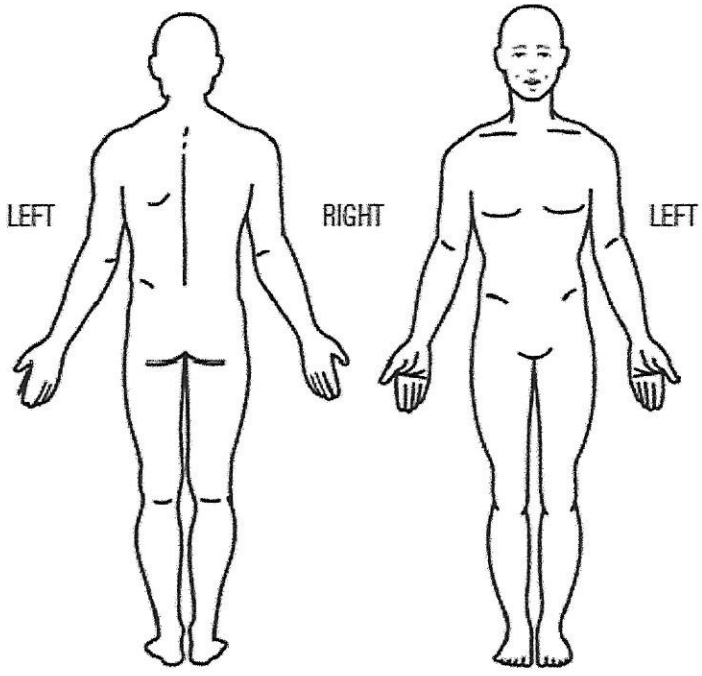
_____

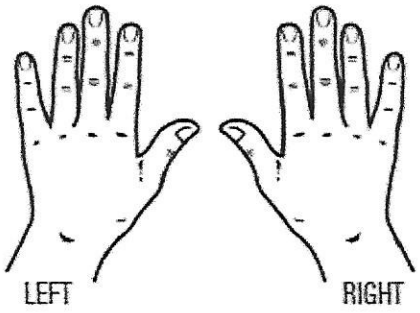
Please complete to the best of your ability

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands.**

Example:







Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

Please complete to the best of your ability

Have you ever been told you had the following?(please circle):				Anemia	Cancer
TB	Asthma	COPD	Other Lung Problems	Kidney Disease	
Heart Attack		Heart Failure	Heart Rhythm Problem	Hypertension	
Liver problems/Hepatitis		Thyroid Problems	Diabetes	Stroke	
Stomach Ulcer		Heartburn/Reflux problems	Seizures	Depression	

Do any blood relatives have the following?(please circle):				Anemia	Cancer
TB	Asthma	COPD	Other Lung Problems	Kidney Disease	
Heart Attack		Heart Failure	Heart Rhythm Problem	Hypertension	
Liver problems/Hepatitis		Thyroid Problems	Diabetes	Stroke	
Stomach Ulcer		Heartburn/Reflux problems	Seizures	Depression	

Have you OR a blood relative ever been diagnosed with the following?

Psoriasis	YES	NO	Spondyloarthropathy	YES	NO
Psoriatic Arthritis	YES	NO	Gout	YES	NO
Crohn's Disease	YES	NO	Osteoarthritis	YES	NO
Ulcerative Colitis	YES	NO	Lupus	YES	NO
Iritis or Uveitis	YES	NO	Sjogren's syndrome	YES	NO
Rheumatoid Arthritis	YES	NO	Scleroderma	YES	NO
Ankylosing Spondylitis	YES	NO	Arthritis, unknown type	YES	NO
Other arthritis problem	YES	NO	Osteoporosis	YES	NO

Do you currently smoke cigarettes?	YES	NO	Do you ever drink alcohol ?	YES	NO
How many packs/day on average?			How many drinks a week on average?		
Did you smoke cigarettes in the past?	YES	NO			
Year quit smoking					

Do you currently smoke/use marijuana, cocaine, meth, heroin ect...?			YES	NO
What drug?				
Did you in the past?	YES	NO	Year quit	

Are you currently employed?	YES	NO	RETIRED	Homemaker
What type of job do you/did you do?				

Please list any past surgeries, reason, and year

Surgery	What for?	Year
Example below		
right knee surgery	*torn meniscus*	*2006*

NAME:

Daniel F. Brandt MD Inc.REVIEW OF SYSTEMS

Have you recently or significantly had any of the symptoms/problems listed below?
PLEASE MARK YES OR NO. IF YES, PLEASE ELABORATE IN THE SPACE PROVIDED

Fever	Yes	No
Frequent sweats at night	Yes	No
Fatigue	Yes	No
Unintentional weight loss	Yes	No
New vision problems	Yes	No
Dry eyes	Yes	No
Other eye problems	Yes	No
Frequent sinus problems	Yes	No
Dry mouth	Yes	No
Frequent mouth sores	Yes	No
Swollen ears	Yes	No
Chest pain	Yes	No
Heart rhythm problems	Yes	No
Swelling In legs	Yes	No
Other heart problems	Yes	No
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Other lung problems	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Heartburn	Yes	No
Diarrhea	Yes	No
Blood in stools	Yes	No
Abdominal pain	Yes	No
Problems swallowing	Yes	No
Other stomach/gut problems	Yes	No

Problems urinating	Yes	No
Pain with urination	Yes	No
Other bladder/prostate problems	Yes	No
Penis/Vagina discharge or sores	Yes	No
Other private part problems	Yes	No
Any rash	Yes	No
Problems with sun exposure	Yes	No
Skin thickening	Yes	No
Patchy hair loss	Yes	No
Significant hair thinning	Yes	No
Fingers change color in the cold	Yes	No
(white, blue, or purple)	Yes	No
Other skin problems	Yes	No
Headaches Dizziness	Yes	No
Numbness/Tingling	Yes	No
Other neurologic problems	Yes	No
Depression	Yes	No
Anxiety	Yes	No
Sleeping problems	Yes	No
Agitation	Yes	No
Other emotion issues	Yes	No
Swollen glands	Yes	No
Easy bruising or bleeding	Yes	No
Problems with blood counts	Yes	No
Frequent infections	Yes	No
Allergic problems	Yes	No