


REVIEW OF SYSTEMS

Please read all these questions carefully.

Answer  questions with a " " if your answer is yes.

A. General

Do you:

- worry a lot about your health?
- feel depressed most of the time?
- enjoy things less now than in the past?
- excessive daytime sleepiness?
- have less/no interest in sexual relations?
- have a recent 10 lb. weight gain or loss?
- have a recent loss of appetite?
- less ambition now than in the past?
- have poor concentration or mood swings?
- consider yourself very nervous?
- have thoughts of committing suicide?
- have hallucinations?
- balance your own checkbook?
- drive at least once a week?

B. Skin

Have you noticed:

- new or changed skin growths or moles?
- excessively dry skin or rashes?
- any sores or wounds that do not heal?

C. Eyes

Have you:

- had an eye exam in the last 3 yrs.?
- been diagnosed with glaucoma ?
- had any temporary loss of vision?
- partial disruption (blurred or lights) of vision?

D. ENT

Do you have:

- trouble hearing with background noise?
- recent difficulty swallowing solid food?
- a habit of regular teeth brushing?
- frequent or severe nosebleeds?
- chronic (constant) hoarseness?
- sores or growths in your mouth or throat?
- bleeding gums despite regular brushing?

E. Respiratory

Do you have or have you had:

- coughing up of blood tinged phlegm?
- excessive phlegm production and no cold?
- shortness of breath?
- wheezing or inability to breathe well?
- frequent chest colds or bronchitis?
- a cough now lasting over two weeks?
- breathing difficulty climbing stairs?

F. Cardiovascular

Do you have or have you had:

- pressure or tightness in your chest?
- episodes of rapid or irregular heart beats?
- to sleep sitting upright to breathe better?
- leg cramps after lying down to rest?
- leg pain with walking and relieved with rest?
- pain in your fingers or toes with cold ?
- chest discomfort walking to the "Dome"?

G. Gastrointestinal

Do you have or have you had:

- indigestion or heartburn frequently?
- trouble with eating fried or greasy foods?
- gas or diarrhea after eating milk products?
- regularly use something for indigestion?
- stomach pain after spicy or acidic foods?
- recent change in bowel habits?
- frequent constipation or diarrhea?
- a colonoscopy with in the last five years
- vomiting of blood or "coffee grounds" ?
- ever have pitch black stools?
- have a sour taste in your mouth at night?
- take laxatives more than twice a week?
- have frequent nausea or vomiting?
- red blood in your stool or on toilet tissue?
- over 3 days between bowel movements?

H. Genitourinary

Do you have or have you had:

- anything wrong with your genitals?
- burning or pain when you urinate?
- urination more than ten times a day?
- had a PSA test or prostate exam (men)?
- difficulty beginning or stopping urination?
- urination more than twice a night?
- loss of urine with a cough or sneeze?
- blood in your urine (without an infection)?

I. Musculoskeletal

Do you have or have you had:

- more than 4 days of severe back pain?
- pain or stiffness in your joints?
- trouble walking due to hip or knee discomfort?
- access to exercise equipment?
- regular use of tylenol, aspirin or ibuprofen?
- visits to an orthopedist or chiropractor?
- any falls in the last 6 months?

J. Central Nervous System

- Do you or have you had:
- frequent or severe headaches?
 - frequent lightheadedness or dizziness?
 - temporary impairment or loss of vision?
 - temporary difficulty speaking?
 - loss of consciousness?
 - convulsions or seizures?
 - numbness in arms, face, or legs?
 - diminished hearing or sense of smell?
 - difficulty keeping your legs still in bed?

Yes

K. Women only

- Have you passed menopause (or change)?
- Do you have or have you had:
- heavy or frequent menstrual periods?
 - yearly Pap smears with a gynecologist?
 - any unusual or new lumps in your breasts?
 - a habit of monthly self breast exams?
 - a chance of being pregnant now?
 - any discharge from your nipples?
 - a history of miscarriages or stillbirths?
 - a bone density or D.E.X.A. scan ?

Yes

Check a box if you have or have had:

- | | | | |
|--|---|-------------------------------------|---|
| high blood pressure <input type="checkbox"/> | any heart <input type="checkbox"/> | surgery <input type="checkbox"/> | erectile dysfunction <input type="checkbox"/> |
| | condition | | |
| diabetes <input type="checkbox"/> | high cholesterol <input type="checkbox"/> | hepatitis <input type="checkbox"/> | anxiety <input type="checkbox"/> |
| | | vaccine | |
| emphysema or <input type="checkbox"/> | cancer <input type="checkbox"/> | depression <input type="checkbox"/> | travel outside the <input type="checkbox"/> |
| asthma | | | U.S. |

Additional Information and Comments:

Have you had any medical or surgical problems or questions for Dr. Erlebacher that you have not already indicated on this form? If there is any further information you would like to discuss that this form has not brought out, please write it down in the space below:

Please enter the names of your prior or current physicians:

(All patients please complete the section below.)

Patient Insurance Information

Employer: _____ Social Security # : _____

Insurance Carrier: (Medicare,CIGNA, United Health, MVP, Excellus, POMCO, Aetna, HealthNow etc.):

Primary: _____	Secondary: _____
ID No. : _____	ID No. : _____
Group No. : _____	Group No. : _____
Subscriber : _____	Subscriber : _____
Co-payment : _____	Co-payment : _____

(Medicare patients only)

<< STATEMENT TO AUTHORIZE MEDICARE BENEFITS >>

I certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I authorize release of my medical information to the Social Security Administration or it's Carriers, any information required to process my Medicare claims.

Signature

Date

Mark S. Erlebacher, MD, FACP, 7000 East Genesee Street, Fayetteville, NY 13066, Telephone: 315-446-5428

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