Phillips Clinic
Be well. Stay well. Age well.

5970C S. Rainbow Blvd. Suite 100
Las Vegas, Nevada 89118
(P) 702-363-4000
(F) 702-362-0086
www.phillipsclinicIv.com

SYSTEMS REVIEW

Medication Allergies: _____
Medication Failures: _____
Medications and Supplements Presently Being Taken (include dose, frequency, etc.):
_____
_____
_____
_____

Please check and describe any of the items below which presently bother you.

☐ Decreased Hearing
☐ Ringing in Ear
☐ Frequent Ear Infections
☐ Failing Vision ☐ Wear Glasses/Contact Lenses
☐ Double or Hazy Vision
☐ Eye Pain
☐ Frequent Eye Infections
☐ Recurrent Nose Bleeds
☐ Chronic Sinus Trouble
☐ Frequent Sore Throats
☐ Hay Fever/Allergies
☐ Prolonged Hoarseness
☐ Snoring ☐ Stop Breathing at Night
☐ Bronchitis
☐ Persistent Cough
☐ Asthma/Wheezing
☐ Shortness of Breath with Exertion
☐ Shortness of Breath when lying flat
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Palpitations
☐ Irregular Pulse
☐ Swollen Ankles
☐ Fainting Spells
☐ Leg Pain when Walking
☐ Varicose Veins ☐ Phlebitis
☐ Loss of Appetite
☐ Difficulty Swallowing
☐ Indigestion/Heartburn
☐ Persistent Nausea or Vomiting
☐ Peptic Ulcers
☐ Abdominal Pain
☐ Changes in bowel habits - recent
☐ Diarrhea ☐ Constipation
☐ Diverticulosis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Gallbladder Issues
☐ Jaundice or Hepatitis
☐ Hernia (where _____)
☐ Frequent Urinary Infections (how often_____)
☐ Painful Urination
☐ Blood in Urine
☐ Overnight Urination (how often _____)
☐ Poor Control of Urination
☐ Decreased Force of Urination
☐ Kidney Stones
☐ Inadequate Erections
☐ Rarely Awaken with Erection
☐ Premature Ejaculation
☐ Inability to or Inadequate Climax
☐ Urinary/Penile Discharge
☐ Breast Changes of any type
☐ Decreased Sexual Interest
☐ Hot Flashes
☐ Fatigue
☐ Recent Weight Loss
☐ Anemia
☐ Bruise Easily
☐ Cancer (Type, Treatment, etc.)
☐ Diabetes ----------->
☐ Thyroid Disease
☐ Convulsions or Seizures
☐ Stroke
☐ Tremors or Shaking
☐ Muscle Weakness
☐ Numbness or Tingling
☐ Frequent Headaches
☐ Joint Pain and/or Swelling
☐ Muscle, Tendon or Bone Pain
☐ Back/Neck Pain
☐ Gout
☐ Foot Pain
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Cold or Numb Extremities
☐ Sleeping Difficulties
☐ Nervousness/Anxiety/PTSD
☐ Depression
☐ Memory Loss
☐ Moodiness
☐ Phobias
☐ Mental Illness

DIABETICS:
Year Diagnosed:_____
Freq. of BS Checks:_____
Ave. Fasting BS:_____
Last Eye Exam:_____
Neuropathy (nerve pain) issues? ☐ No ☐ Yes
☐ Better ☐ Stable ☐ Worse
Where:_____

Female General History

☐ Vaginal discharge or burning ☐ Vaginal dryness
☐ Pain or bleeding with or after sex
☐ Hot Flashes
☐ Night Sweats
☐ Irritability
☐ Abnormal Pap Smear

Last Pap/Pelvic Exam:
_____

Menstrual History:
Age periods began _____
Menses Description:
☐ Regular ☐ Irregular
☐ Heavy ☐ Moderate ☐ Light ☐ Painful
Ave. Days of Flow _____
Length of Cycle _____
Date of Last Period _____
Age at Menopause _____
Pregnancy History:
No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
No. of Abortions _____
Birth Control Method:
☐ None
☐ BC Pills
☐ Rhythm
☐ Other

Name: _____ **Chart #:** _____ **Date:**_____

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HISTORY

Family History – Please list any that apply: diseases, cause of death, age at death, chemical dependencies, psychiatric disorders, etc.

Father	
Mother	
Grandparents - Father's side	
Grandparents - Mother's side	
Siblings	
Uncles	
Aunts	
Cousins	
Children - Son(s) #____ - Daughter(s) #____	

Social History

Religion	
Work	☐ Retired ☐ Unemployed Describe Occupation:
Marital Status	☐ Single ☐ Married x ☐ Divorced x ☐ Widowed x ☐ Homosexual ☐ Bisexual
Military	☐ None ☐ Yes, Branch of Service_____ Years_____ Describe any service connected disability/injury_____
Hobbies	☐ None Other List:
Exercise	☐ None Yes…Describe (times per week, length of time, type of activities):
Addiction	☐ Never ☐ Street drugs: ☐ Prescription drugs: IV use (needles) ☐ Yes ☐ No and If Yes Please List: Other:
Alcohol	☐ Never/Rarely or Please list the average amounts for each per week, month, or year: Beer (can) Wine (glass) Hard Liquors (oz) Recovering Alcoholic since:
Nicotine	☐ Never ☐ Smoke ☐ Chew Age started: Age stopped: Amount/day:
Caffeine	☐ Never Coffee cups/day: Tea cups/day: Sodas cans/day: Energy drinks/day:

Past Illnesses & Health Conditions:

Yes	No	
☐	☐	Hepatitis (Onset_____)
☐	☐	HIV/AIDS (Onset_____)
☐	☐	Herpes (Onset_____)
☐	☐	Genital Warts (Onset_____)
☐	☐	Tuberculosis (Onset_____)
☐	☐	Chicken Pox
☐	☐	Obstructive Sleep Apnea (Onset_____, CPAP - Y N)
☐	☐	High Blood Pressure (Onset_____)
☐	☐	High Cholesterol (Onset_____)
☐	☐	Heart Attack (Yr_____)
☐	☐	Heart Murmur (Onset_____)
☐	☐	Rheumatic Fever (Onset_____)
☐	☐	Previous Stent/Angiogram (Yr_____)
☐	☐	Diabetes (Onset_____)
☐	☐	Thyroid Problems (Onset_____)

Yes	No	
☐	☐	Liver Disease (Onset_____)
☐	☐	Kidney Disease (Onset_____)
☐	☐	Psychiatric Issues (Onset_____) (Type_____)
☐	☐	Prostate Problems (Onset_____)
☐	☐	Stroke/TIA (Onset_____)
☐	☐	Seizure Disorder (Onset_____)
☐	☐	Glaucoma (Onset_____)
☐	☐	Gout (Onset_____)
☐	☐	Arthritis (Onset_____)
☐	☐	Back Pain (Onset_____)
☐	☐	Anemia (Onset_____)
☐	☐	Blood Clots (Onset_____)
☐	☐	Bleeding Problems (Onset_____)
☐	☐	Cancer (Onset_____Type_____) (Treatment_____)

Past Surgical and Medical History

Age/Year	Please list below any hospitalizations, surgeries, or major injuries including reason and complications when appropriate.

Vaccinations – Please list the date or year last given

Tetanus/Diptheria (Td)	
Tetanus/Diptheria/Pertussis (Tdap)	
Hepatitis A (series of 2 shots)	
Hepatitis B (series of 3 shots)	
HPV (e.g. Gardasil) (series of 3 shots)	
Pneumococcal	
Meningococcal	
Shingles (Zostavax)	

Name:_____ **Chart #:**_____ **Date:**_____