GUILLERMO MARRERO, MD., P.A.
1000 Executive Dr. Ste 1
Oviedo, FL 32765

HISTORY / REVIEW OF SYSTEMS

Please indicate any personal history below:

Patient Name: ______________________________

MEDICAL PROBLEMS	CURRENT MEDICATION	HOSPITALIZATIONS or SURGERIES (Aprox. Year)	ALLERGIES

CONSTITUTIONAL SYMPTOMS

- Good general health lately N Y
- Recent weight change N Y
- Fever N Y
- Fatigue N Y
- Headaches N Y

EAR/NOSE/MOUTH/THROAT

- Hearing loss or ringing N Y
- Earaches or drainage N Y
- Chronic sinus problem or rhinitis N Y
- Nose bleeds N Y
- Mouth sores N Y
- Bleeding gums N Y
- Bad breath or bad taste N Y
- Sore throat or voice change N Y
- Swollen glands in neck N Y

ENDOCRINE

- Glandular or hormone problem N Y
- Thyroid disease N Y
- Diabetes (*Insulin or non-Insulin*) N Y
- Excessive thirst or urination N Y
- Heat or cold intolerance N Y
- Skin becoming dryer N Y
- Change in hat or glove size N Y

MUSCULOSKELETAL

- Joint pain N Y
- Joint stiffness or swelling N Y
- Weakness of muscles or joints N Y
- Muscle pain or cramps N Y
- Back Pain N Y
- Cold extremities N Y
- Difficulty in walking N Y

INTEGUMENTARY (skin, breast)

- Rash or itching N Y
- Change in skin color, hair or nails N Y
- Varicose veins N Y
- Breast pain N Y
- Breast lump N Y
- Breast discharge N Y

NEUROLOGICAL

- Frequent or recurring headaches N Y
- Light headed or dizzy N Y
- Convulsions or seizures N Y
- Numbness or tingling sensations N Y
- Tremors N Y
- Paralysis N Y
- Stroke N Y
- Head Injury N Y

EYES

- Eye disease or injury N Y
- Glasses/contact lenses N Y
- Blurred or double vision N Y
- Glaucoma N Y

PSYCHIATRIC

- Memory loss or confusion N Y
- Nervousness N Y
- Depression N Y
- Insomnia N Y

RESPIRATORY

- Chronic or frequent coughs N Y
- Spitting up blood N Y
- Shortness of breath N Y
- Asthma or Wheezing N Y

HEMATOLOGIC / LYMPHATIC

- Slow to heal after cuts N Y
- Bleeding/bruising tendency N Y
- Anemia N Y
- Phlebitis N Y
- Past transfusion N Y
- Enlarged glands N Y

GASTORINTESTINAL

- Loss of appetite N Y
- Change in bowel movements N Y
- Nausea or vomiting N Y
- Frequent diarrhea N Y
- Painful bowel movements or constipation N Y
- Rectal bleeding or blood in stool N Y
- Abdominal pain N Y
- Peptic ulcer (stomach or duodenal) N Y

CARDIOVASCULAR

- Heart trouble N Y
- Chest pain or angina pectoris N Y
- Palpitation N Y
- Shortness of breath with walking or lying flat N Y
- Swelling of feet, ankles or hands N Y
- High blood pressure N Y

GENITOURINARY

- Frequent urination N Y
- Burning or painful urination N Y
- Blood in urine N Y
- Change in force of strain when urinating N Y
- Incontinence or dribbling N Y
- Kidney stones N Y
- Sexual difficulty N Y
- Male - testicle pain N Y
- Female - pain with periods N Y
- Female - irregular periods N Y
- Female - vaginal discharge N Y
- Female - hysterectomy N Y
- Female - tubal ligation N Y
- Female - # of pregnancies ________
- Female - # of miscarriages ________
- Female - date of last pap smear ________

FAMILY HISTORY (Please circle as applies

Heart Disease	High Blood Pressure	Stroke	Cancer	Glaucoma	Diabetes	Epilepsy/ convulsions	Bleeding Disorder	Kidney Disease	Tnyroid Disease	Mental Illness	Osteoporosis
Father	Father	Father	Father	Father	Father	Father	Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother
Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents	Father's Parents
Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents	Mother's Parents
Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings	Siblings
Children	Children	Children	Children	Children	Children	Children	Children	Children	Children	Children	Children

Reviewed By: ______________________________ Date: ______________

(Form 2)