ONTARIO MEDICAL ASSOCIATES
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Patient Name: _____ Date:_____
D.O.B. _____ Age:
□ M □ F

COMPLETE REVIEW OF SYSTEMS

GENERAL MEDICAL REVIEW OF SYSTEMS

Do you suffer from or have you had:

- Recent fever or unusual weight loss, or headaches? ..... No__ Yes
- Hearing loss, sinus problems, or difficulty swallowing? ..... No__ Yes
- Chest pain, irregular heart beat, foot swelling? ..... No__ Yes
- Shortness of breath, chronic cough, bloody sputum? ..... No__ Yes
- Diarrhea, constipation, bloody stools, abdominal pain? ..... No__ Yes
- Urinary problems, genital discharge? ..... No__ Yes
- Muscle aches, joint pains, arthritis? ..... No__ Yes
- Rash, changing skin spots, breast mass, or discharge? ..... No__ Yes
- Memory loss, blackouts, weakness? ..... No__ Yes
- Hallucination, depression, emotional problem? ..... No.__ Yes
- Excessive urination, frequent thirst, fatigue, diabetes, thyroid? ..... No__ Yes
- Bleeding problems, swollen lvmph nodes, frequent infections? ..... No__ Yes
- Other unusual symptoms? _____

.Regular Medical Physician.

PAST MEDICAL HISTORY

DIABETES HEART	ASTHMA	EMPHYSEMA	ULCER
ATTACK CAROTID	THYROID DISORDER	STROKE	SICKLE CELL DISEASE
DISEASE CANCER	RHEUMATOID ARTHRITIS	ANGINA	HIV/AIDS
OTHER:_____	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	

Do you have any health problems? ☐ NO ☐ YES *If yes, please circle below:*

SOCIAL HISTORY

Do you smoke tobacco? ☐ NO ☐ YES _____ *packs per day for* _____ *years*
Do you drink alcohol? ☐ NO ☐ YES *If yes, how much?* _____
Are you working? ☐ NO ☐ YES *If yes, what is your job?* _____

SURGICAL HISTORY

Have you had surgery other than eye surgery? ☐ NO ☐ YES *If yes, please list:*

Have you had any injuries or recent hospitalizations? ☐ NO ☐ YES *If yes, please list:*

CONTINUED ON NEXT PAGE