Jorge A. Saravia MD
Clinical History
Review of Systems
Current Medications

Date	Date of Birth Age
Patient's Name	
What are your main symptoms or concerns?	

Have you had problems with	**Example**	**YES**	**NO**	**Describe and add as necessary**
General Symptoms	Weight Loss			
	Weight gain			
	Fatigue			
	Fever			
	Chills			
	Insomnia			
Skin	Rashes			
	Lumps			
	Eczema			
	Growths			
	Sores			
	Itching			
Lungs	Cough			
	Wheezing			
	Chest Pain			
	Snoring			
	Sleep Apnea			
Heart	Palpitations			
	Orthopnea (Difficulty to breath lying down) Syncope (fainting)			
	Edema (swelling)			
Stomach	Swallow difficulty			
	Stomach ache			
	Heartburn			
	Nausea			
	Vomiting			
	Constipation			
	Diarrhea			
	Rectal bleed			
				Turn Page over...........

Review of Systems

Have you had problems with	**Example**	**YES**	**NO**	**Describe and or add others**
Genito Urinary	Urgency			
	Frequency			
	Burning			
	Incontinence			
	Blood in Urine			
Blood	Easy bruising			
	Easy bleeding			
	Anemia			
Musculoskeletal	Muscle pain, Joint pain Joint redness			
Psychiatric	Depression			
	Anxiety			
	Stress			
	Memory loss			
Endocrine	Heat intolerance			
	Cold intolerance			
	Frequent urination			
	Excessive thirs			
	Apetite change			
Ear, nose and throat	Deafness			
	Ringing in ears			
	Ear ache			
	Nose bleeds			
	Sore throat			
Allergic/Immu-nologic	List youraAllergies			

List all medications currently taking			
Medication	**Dose**	**Prescribed by**	**Prescribed for**