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Personal History

Review of Systems

Do you have, or have you ever had the following problems:

Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hiatal Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irritable Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diverticulosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swallowing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction to Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina (Heart Pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (liver disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

Do you currently have any of the following problems:

Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intolerance to heat, cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food or inhalant allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History

Do any of your immediate family members (blood relatives) suffer from:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irritable Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Colon	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Ovarian	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please Continue on to page 3

