

**Sibley Physician Group  
Colette Magnant, M.D.  
RETURN PATIENT CARE RECORD**

**PATIENT NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

Any changes in medical history? \_\_\_\_\_

List **ALL** allergies: \_\_\_\_\_

Any surgeries since last visit? \_\_\_\_\_

Any changes in your hormonal history? \_\_\_\_\_

Any newly diagnosed cancers in your family since last visit? \_\_\_\_\_

List **ALL** medications you are currently taking, including over the counter medications and vitamins.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**REVIEW OF SYSTEMS:** Have you recently experienced any of the following problems  
(Please check that are applicable)

<b>GENERAL:</b>	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Night sweats
<b>NEUROLOGICAL:</b>	<input type="checkbox"/> Headache	<input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizure
<b>CARDIAC:</b>	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Feet swelling	<input type="checkbox"/> Short of breath lying flat	
<b>RESPIRATORY:</b>	<input type="checkbox"/> Cough	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Shortness of breath		
<b>ABDOMINAL:</b>	<input type="checkbox"/> Pain	<input type="checkbox"/> No appetite	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Constipation /Diarrhea
<b>URINARY:</b>	<input type="checkbox"/> Difficulty	<input type="checkbox"/> Pain	<input type="checkbox"/> Frequency	<input type="checkbox"/> Urgency	<input type="checkbox"/> Blood in urine /Urinary tract infection
<b>GYN:</b>	<input type="checkbox"/> Spotting	<input type="checkbox"/> Discharge	<input type="checkbox"/> Irregular periods		
<b>M/SKELETAL:</b>	<input type="checkbox"/> Back pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Aches and pains		
<b>PSYCHIATRIC:</b>	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Suicidal thoughts		
<b>OTHERS:</b>	<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Tremors	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Feeling excessively hot or cold

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_