

**Appointment  
ROS Sheet**

**FULL CIRCLE MEDICAL CENTER**  
4085 Cloud Springs Road  
Ringgold, GA 30736  
706-861-7377

**Appointment Time:**  
\_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

WHAT DO WE TALK ABOUT TODAY ? OLD / CHRONIC / ON-GOING PROBLEMS

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

ANY SURGERIES / OPERATIONS / DENTAL WORK IN LAST 6 MONTHS \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

**CIRCLE:** MALE / FEMALE MARRIED WIDOWED DIVORCED SEPARATED SINGLE

OCCUPATION NOW: \_\_\_\_\_ PAST: \_\_\_\_\_

PAST EXPOSURE TO TOXINS / METALS / BIOHAZARDS: \_\_\_\_\_

EXERCISE: REGULAR OCCASIONAL NONE WALKING DISTANCE: NO LIMIT MUST STOP @ \_\_\_\_\_

BEER WINE LIQUOR NEVER RARELY OCCASIONALLY DAILY TOBACCO: SMOKE ORAL NONE

PRESENT PAST NO PROBLEMS/EXCESS: ALCOHOL COCAINE METH NARCOTICS GAMBLING OTHER

PLEASE **CIRCLE** Y or N PLEASE **CIRCLE** ANY SYMPTOMS ACHES PAINS PROBLEMS

Y N VISUAL CHANGES Y N HEARING PROBLEMS Y N SWALLOWING PROBLEMS

Y N CHEST PAIN ARM PAIN NECK PAIN LEG PAIN IRREGULAR HEART BEAT PALPITATIONS

Y N BREATHING PROBLEMS SHORTNESS OF BREATH COUGH CAN'T LIE DOWN

Y N CONSTIPATION DIARRHEA BLOOD IN STOOL CHANGE IN SIZE, SHAPE COLOR OF STOOLS

Y N BLADDER PROBLEMS STARTING STOPPING URGENT LEAKAGE / LEAK WITH STRESS BLOOD

Y N ACHES/PAINS JOINTS MUSCLES BONES FOR WHICH YOU HAVE NO GOOD EXPLANATION

Y N SWELLING IN FEET LEGS Y N WEIGHT LOSS WEIGHT GAIN

Y N SEXUAL PROBLEMS LOSS OF DESIRE PAIN WITH INTERCOURSE ERECTILE DYSFUNCTION  
VAGINAL DRYNESS HOT FLASHES NIGHT SWEATS

Y N CHANGE IN MOOD DEPRESSION FEELING SAD IMPULSE ANGER ANXIETY PANIC ATTACKS

Y N TROUBLE GOING TO SLEEP TROUBLE STAYING ASLEEP # \_\_\_\_\_TIMES UP TO URINATE @ NIGHT

OTHER: \_\_\_\_\_

SINCE THE LAST VISIT, DO YOU FEEL: THE SAME WORSE BETTER

Explain what activity makes it better and/or worse: \_\_\_\_\_

Pain scale ☺ 0—1—2—3—4—5—6—7—8—9—10 ☹ Zero = no pain  
Ten = Screaming Child Birth / Kidney Stone Pain

**USE THE OTHER SIDE FOR YOUR CURRENT VITAMINS, MINERALS, AND PRESCRIPTIONS**

Patients Signature: \_\_\_\_\_ Physicians Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_