

Review of systems: Please indicate any of the following symptoms experienced in the last year:

Constitutional Symptoms

Good general health lately... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Headache..... No Yes

Eyes

Eye disease or injury..... No Yes
 Wear glasses/contacts No Yes
 Glaucoma/cataracts..... No Yes
 Blurred or double vision.... No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problem
 or Allergies..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Sore throat or voice change.. No Yes
 Swollen glands in neck..... No Yes
 Goiter..... No Yes

Cardiovascular

Heart trouble..... No Yes
 Chest pain/angina pectoris... No Yes
 Palpitation..... No Yes
 Shortness of breath w/
 walking or lying flat..... No Yes
 Swelling of feet, ankles,
 or hands..... No Yes
 Heart murmur..... No Yes

Respiratory

Chronic or frequent coughs... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Wheezing..... No Yes
 Emphysema..... No Yes

Gastrointestinal

Loss of appetite..... No Yes
 Change in bowel movements No Yes
 Nausea or vomiting..... No Yes

Frequent diarrhea..... No Yes
 Painful bowel movements
 or constipation..... No Yes
 Rectal bleeding or blood in
 stool..... No Yes
 Abdominal pain..... No Yes
 Burning or painful urination.. No Yes
 Blood in urine..... No Yes

Genitourinary

Frequent urination..... No Yes
 Incontinence..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
 Male – testicle pain..... No Yes
 Female – pain with periods... No Yes
 Female- irregular periods.... No Yes
 Female- vaginal discharge.... No Yes
 Female- # of pregnancies.... _____
 Female- # of miscarriages.... _____
 Female- date of last pap smear _____
 Female- date of last period _____
 Postmenopausal bleeding... No Yes

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles
 or joints..... No Yes
 Back pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes
 Gout..... No Yes

Integumentary (skin, breast)

Change in mole..... No Yes
 Rash or itching No Yes
 Change in skin color..... No Yes
 Change in hair color..... No Yes
 Varicose veins No Yes
 Breast pain..... No Yes
 Breast discharge..... No Yes
 Breast lump..... No Yes
 Date of last mammogram _____

Psychiatric

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

Neurological

Frequent or recurring
 headaches..... No Yes
 Light headed or dizzy..... No Yes
 Convulsions..... No Yes
 Numbness or tingling
 sensation..... No Yes
 Tremors No Yes
 Paralysis..... No Yes
 Head injury..... No Yes

Endocrine

Glandular or hormone
 Problem No Yes
 Excessive thirst or urination... No Yes
 Heat or cold intolerance..... No Yes
 Skin becoming dryer..... No Yes
 Excessive Sweating..... No Yes

Hematologic/Lymphatic

Slow to heal after cuts No Yes
 Easily bruise or bleed..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

Allergic/Immunologic

History of skin reaction or other
 adverse reaction to:

 Known food allergies:

 Environmental allergies:

Provider's Review:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is important to my health that I provide accurate information and report any changes in my health to the doctor.

Patient's Signature _____ Date _____
 Provider's signature _____ Date _____