Review of Systems

DO YOU CURRENTLY HAVE..... (YOU MUST CHECK AND ANSWER FOR EACH INDIVIDUAL ITEM)

CONSTITUTIONAL SYMPTOMS		GASTROINTESTINAL		MUSCULOSKELETAL	
Weight Loss	{ } YES { } NO	Hepatitis (or history of}	{ } YES { } NO	Arthritis/Joint Pain	{ } YES { } NO
EYES	{ } YES { } NO	Yellow Jaundice	{ } YES { } NO	Fracture of Neck (or history of)	{ } YES { } NO
Glaucoma	{ } YES { } NO	Gallstones	{ } YES { } NO	Fracture of Spine (or history of)	{ } YES { } NO
Glasses or Contact Lenses	{ } YES { } NO	Gallbladder Trouble	{ } YES { } NO	**NEUROLOGICAL**	
Dry Eyes, Excess Tearing	{ } YES { } NO	Cirrhosis of the Liver	{ } YES { } NO	Tingling or Numbness	{ } YES { } NO
EARS, NOSE, MOUTH AND THROAT		Ulcers	{ } YES { } NO	Weakness in Extremities	{ } YES { } NO
Decreased Hearing	{ } YES { } NO	Gastritis/Colitis	{ } YES { } NO	Seizures/convulsions	{ } YES { } NO
Airway Obstruction (Nasal)	{ } YES { } NO	Constipation	{ } YES { } NO	Fainting spells/Black outs	{ } YES { } NO
CARDIOVASCULAR		Chronic Adbominal Pain	{ } YES { } NO	Stroke	{ } YES { } NO
Heart Attack	{ } Yes { } NO	Hernia: Hiatal	{ } YES { } NO	Palsy or Paralysis (what level}	{ } YES { } NO
Chest Pain/Angina	{ } Yes { } NO	Abdominal	{ } YES { } NO	**PSYCHIATRIC**	
Palpitation or Irregular Heartbeat	{ } Yes { } NO	Groin	{ } YES { } NO	Nervous Breakdown	{ } YES { } NO
Heart murmur	{ } Yes { } NO	Heartburn/Indigestion	{ } YES { } NO	Anxiety Disorder	{ } YES { } NO
High Blood Pressure	{ } Yes { } NO	**GENITOURINARY**		Insomnia	{ } YES { } NO
Low Blood Pressure	{ } Yes { } NO	Kidney Disorder	{ } YES { } NO	Alcohol Addiction	{ } YES { } NO
Abnormal EKG	{ } Yes { } NO	Blood in Urine	{ } YES { } NO	Drug Dependency	{ } YES { } NO
Rheumatic Fever	{ } Yes { } NO	Kidney Infection (or history of)	{ } YES { } NO	Self-Destructive Tendencies	{ } YES { } NO
On Heart Medication	{ } Yes { } NO	Bladder Infection (or history of)	{ } YES { } NO	Bipolar Disorder/Depression	{ } YES { } NO
Heart Failure	{ } Yes { } NO	Kidney Stones (or history of)	{ } YES { } NO	Psychiatric Hospitalization	{ } YES { } NO
Swelling in Ankles	{ } Yes { } NO	Difficulty Urinating	{ } YES { } NO	**ENDOCRINE**	
Chest Pain with Exercise	{ } Yes { } NO	Urinary Retention	{ } YES { } NO	Thyroid Problems/Goiter	{ } YES { } NO
RESPIRATORY		**SKIN**		Diabetes	{ } YES { } NO
Asthma/Wheezing	{ } YES { } NO	Skin Disorders, Dermatitis	{ } YES { } NO	Insulin Dependency?	{ } YES { } NO
Bronchitis	{ } YES { } NO	Heavy Sun Exposure/Tanning Beds	{ } YES { } NO	Diabetic foot ulcers/infection	{ } YES { } NO
Pneumonia (or history of)	{ } YES { } NO	Blistering Sunburn in Past	{ } YES { } NO	Cortisone Treatment	{ } YES { } NO
Tuberculosis	{ } YES { } NO	Rash	{ } YES { } NO	Steroid Treatment	{ } YES { } NO
Smoker Cough	{ } YES { } NO	Skin Cancer (or history of)	{ } YES { } NO	**HEMATOLOGIC/LYMPHATIC**	
Emphysema	{ } YES { } NO	Changes in Moles (growth/color)	{ } YES { } NO	Bleeding Tendency or Disorder	{ } YES { } NO
Shortness of Breath	{ } YES { } NO	Pressure Ulcers/Diabetic Ulcers	{ } YES { } NO	Abd. Bleeding after Tooth	
Chronic Breathing Difficulty	{ } YES { } NO	**INFECTIOUS**		Extraction	{ } YES { } NO
Other Lung Problems	{ } YES { } NO	Postive blood test for:		Blood Transfusion	{ } YES { } NO
ALLERGIC/IMMUNOLOGIC		AIDS/Hepatitis/HIV	{ } YES { } NO	Anemia	{ } YES { } NO
Hay Fever	{ } YES { } NO			Easy Bruising	{ } YES { } NO
Major Allergies	{ } YES { } NO			Lymphedema	{ } YES { } NO
Lupus, Scleroderma	{ } YES { } NO				
Rheumatoid Arthritis	{ } YES { } NO				

Health Questions

*When was your last physical exam? _____ and by whom? _____

*Have you had recent blood work? _____ { } YES { } NO Where? _____

*Is there anything else you think the doctor should know? _____

_____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Reviewed by: _____