**REVIEW OF SYSTEMS**

**First Name** **Middle Initial** **Last Name**

Check the box if you are **currently** experiencing any of the following:

|  |  |  |
| --- | --- | --- |
| **General** | **Skin** | **Respiratory** |
| 🞐 Arthritis/Rheumatism | 🞐 Abnormal Pigmentation | 🞐 Any Lung Troubles |
| 🞐 Back Pain (recurrent) | 🞐 Boils | 🞐 Asthma or Wheezing |
| 🞐 Bone Fracture | 🞐 Brittle Nails | 🞐 Bronchitis |
| 🞐 Cancer | 🞐 Dry Skin | 🞐 Chronic or Frequent Cough |
| 🞐 Diabetes | 🞐 Eczema | 🞐 Difficulty Breathing |
| 🞐 Foot Pain | 🞐 Frequent infections | 🞐 Pleurisy or Pneumonia |
| 🞐 Gout | 🞐 Hair/Nail changes | 🞐 Spitting up Blood |
| 🞐 Headaches/Migraines | 🞐 Hives | 🞐 Trouble Breathing |
| 🞐 Joint Injury | 🞐 Itching | 🞐 URI (Cold) Now |
| 🞐 Memory Loss | 🞐 Jaundice | 🞐 None |
| 🞐 Muscle Weakness | 🞐 Psoriasis |  |
| 🞐 Numbness/Tingling | 🞐 Rash |  |
| 🞐 Obesity | 🞐 Skin Disease |  |
| 🞐 Osteoporosis | 🞐 None |  |
| 🞐 Rheumatic Fever |  |  |
| 🞐 Weight Gain/Loss |  |  |
| 🞐 None |  |  |

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| **Cardiovascular** | **Gastrointestinal** | **Eyes - Ears - Nose - Throat/Mouth** |
| 🞐 Awakening in the night smothering | 🞐 Abdominal Pain | 🞐 Blurring |
| 🞐 Chest Pain or Angina | 🞐 Appetite Changes | 🞐 Double Vision |
| 🞐 Congestive Heart Failure | 🞐 Black Stools | 🞐 Eye Disease or Injury |
| 🞐 Cyanosis (blue skin) | 🞐 Bleeding with Bowel Movements | 🞐 Eye Pain/Discharge |
| 🞐 Difficulty walking two blocks | 🞐 Blood in Vomit | 🞐 Glasses |
| 🞐 Edema/Swelling of Hands, Feet or Ankles | 🞐 Crohn’s Disease/Colitis | 🞐 Glaucoma |
| 🞐 Heart Attacks | 🞐 Constipation | 🞐 Itchy Eyes |
| 🞐 Heart Murmur | 🞐 Cramping or pain in the Abdomen | 🞐 Vision changes |
| 🞐 Heart Trouble | 🞐 Difficulty Swallowing | 🞐 Ear Disease |
| 🞐 High Blood Pressure | 🞐 Diverticulosis | 🞐 Ear Infections |
| 🞐 Irregular Heartbeat | 🞐 Frequent Diarrhea | 🞐 Ears ringing |
| 🞐 Pain in legs | 🞐 Gallbladder Disease | 🞐 Hearing problems |
| 🞐 Palpitations | 🞐 Gas/Bloating | 🞐 Impaired Hearing |
| 🞐 Poor Circulation | 🞐 Heartburn or Indigestion | 🞐 Chronic Sinus Trouble |
| 🞐 Shortness of Breath | 🞐 Hemorrhoids or Piles | 🞐 Itchy Nose |
| 🞐 Varicose Veins/Phlebitis | 🞐 Hepatitis | 🞐 Nosebleeds |
| 🞐 None | 🞐 Hernia | 🞐 Postnasal drip |
|  | 🞐 Liver Trouble | 🞐 Sinusitis |
|  | 🞐 Nausea/Vomiting | 🞐 Sneezing or Runny Nose |
|  | 🞐 Painful Bowel Movements | 🞐 Gum Bleeding |
|  | 🞐 Peptic Ulcer (Stomach or Duodenal) | 🞐 Hoarseness |
|  | 🞐 Recent change in Bowel habits | 🞐 Loss of Taste |
|  | 🞐 None | 🞐 Mononucleosis |
|  |  | 🞐 Sore Throat |
|  |  | 🞐 Sores |
|  |  | 🞐 None |

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| **Genitourinary** | **Hematologic** | **Endocrine** |
| 🞐 Blood in Urine | 🞐 Abnormal Bruising or Bleeding | 🞐 Become colder than before |
| 🞐 Bright’s Disease | 🞐 Anemia | 🞐 Changes in Hair Growth |
| 🞐 Burning or painful Urination | 🞐 Blood Disease | 🞐 Changes in hat or glove size |
| 🞐 Decrease in force/flow | 🞐 Excessive Bleeding after tooth extraction | 🞐 Fatigue Sweating/Night Sweats |
| 🞐 Frequent Urination | 🞐 Phlebitis | 🞐 Fever/Chills |
| 🞐 Incontinence | 🞐 Slow to heal | 🞐 Frequent infections |
| 🞐 Kidney Stones | 🞐 None | 🞐 Goiter |
| 🞐 Kidney Trouble |  | 🞐 Heat/cold intolerance |
| 🞐 Nighttime Urinating |  | 🞐 Hormone Therapy |
| 🞐 Prostate Problems |  | 🞐 Lymph node Enlargement |
| 🞐 None |  | 🞐 Sleep Problems |
|  |  | 🞐 Thyroid Disease |
|  |  | 🞐 Weakness/Paralysis |
|  |  | 🞐 Weight Change |
|  |  | 🞐 None |

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| **Neurological** |
| 🞐 Convulsions/Seizures | 🞐 Paralysis |
| 🞐 Dizziness | 🞐 Psychiatric Care |
| 🞐 Fainting Spells | 🞐 Stroke |
| 🞐 Gait/Coordination | 🞐 Trauma |
| 🞐 Headaches/Migraines | 🞐 Tremor/Hand Shaking |
| 🞐 None |

**Mental Health**

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| --- |
| **Have you ever been diagnosed or treated for Depression and/or Anxiety?** 🞐 Yes 🞐 No |
| **Have you ever been diagnosed or treated for an eating disorder (e.g., Anorexia/bulimia)?** 🞐 Yes 🞐 No |
| **Do you panic when stressed?** 🞐 Yes 🞐 No |
| **Do you have a problem with your appetite when under stress?** 🞐 Yes 🞐 No |
| **Have you ever seriously thought about hurting yourself?** 🞐 Yes 🞐 No |
| **Have you been diagnosed or treated for Bi-Polar disorder?**  🞐 Yes 🞐 No |
| **Do you cry frequently?**  🞐 Yes 🞐 No  |
| **Have you ever attempted suicide?** 🞐 Yes 🞐 No |
| **Do you have trouble sleeping?** 🞐 Yes 🞐 No |
| **Have you ever been to a counselor?** 🞐 Yes 🞐 No |

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| **Do you usually get up to urinate during the night?** 🞐 Yes 🞐 No |
| **Any loss of libido or sex drive?** 🞐 Yes 🞐 No |
| **Have you had any kidney, bladder, or prostate infections within the last 12 months?** 🞐 Yes 🞐 No |
| **Any blood in your urine?** 🞐 Yes 🞐 No |
| **Any difficulty with erection or ejaculation?** 🞐 Yes 🞐 No |

**Men Only**

**Women Only**

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| --- |
| **Heavy periods, irregularity, spotting, pain, or discharge?** 🞐 Yes 🞐 No |
| **Are you pregnant or breastfeeding?** 🞐 Yes 🞐 No |
| **Any hot flashes or sweating at night?** 🞐 Yes 🞐 No |
| **Do you have menstrual tension, bloating, irritability, or other symptoms at or around time of period?** 🞐 Yes 🞐 No |
| **Recurrent vaginal infections?** 🞐 Yes 🞐 No |
| **Pain/bleeding with sex?**  🞐 Yes 🞐 No |

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| **Age at onset of menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of last menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Length of cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Days of flow: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Birth control method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of last PAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**All Patients**

**Is there anything that hasn't been covered above that you would like to add or explain?**

**My signature indicates the above information is correct.**

**Signature of Patient (or Guardian/Authorized Representative):**

**Full Name of above signed (if not patient)**

**Date:**

This information will assist us in assessing your problem areas and establishing your medical management. Thank you for your time and patience in completing this form.