Review of Systems
Please indicate any personal history below:

□ Constitutional Symptoms

Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

□ Eyes

Eye disease or injury	no	yes
Wear glasses/contact lenses	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 problems/rhinitis	no	yes
Nose bleeds	no	yes
Mouth Sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

□ Cardiovascular

Heart trouble	no	yes
Chest Pain or angina pectoris	no	yes
Palpitation	no	yes
Swelling of feet, ankles/hands	no	yes

□ Respiratory

Persistent cough/throat	no	yes
Clearing not associated with a known illness (lasting more than 3 weeks)		
Spitting up blood	no	yes
Shortness of breath	no	yes
Wheezing	no	yes

□ Gastrointestinal

Loss of appetite	no	yes
Change in bowel movement	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Rectal bleeding/blood in stool	no	yes
Abdominal pain		

□ Genitourinary

Frequent Urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force of strain when urinating	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male-testicle pain	no	yes
Female – pain with periods	no	yes
Female – vaginal discharge	no	yes
Female – irregular periods	no	yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female – date of last pap smear	_____	

□ Musculoskeletal

Joint pain	no	yes
Joint stiffness	no	yes
Weakness of muscles or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Difficulty in walking	no	yes

□ Integumentary

Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

□ Neurological

Frequent/recurring headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness/tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes

□ Psychiatric

Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes
Suicidal thoughts	no	yes
Violent or unusual thoughts	no	yes

□ Endocrine

Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming drier	no	yes
Change in hat or glove size	no	yes

□ Hematologic/Lymphatic

Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

□ Allergic/Immunologic

History of skin reaction or other		
Penicillin or other antibiotics	no	yes
Morphine, Demorol or other narcotics	no	yes
Novocain or other anesthetics	no	yes
Aspirin or other pain remedies	no	yes
Tetanus antitoxin or other serums	no	yes
Iodine Methiolate other antiseptic	no	yes

Other drugs/medications _____

_____

Known food allergies _____

_____

Environmental allergies _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____
Patient Name

_____ _____
Signature of Patient/Parent/Guardian Date

HEALTH HISTORY