Review of systems: Please indicate any of the following symptoms experienced <u>in the last year</u>:

□ 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 _____