Review of Systems

PLEASE PRINT

Name: _______________________________________ DOB: ________________________________

Referring MD: _______________________________ Primary MD: _______________________________

Medication allergies: ____

Other Allergies (*please circle if applicable*): **Iodine** **Latex** **Tape**

Medications: (Name, Mg. Dose)

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Family history of: ___Heart Disease ____Lung Disease ____Hypertension ____Kidney Disease

Social History of:

Tobacco: # of packs per day_____ #of year's smoked_____ Date quit_________

Alcohol: # of drinks per day _____#of year's ______ Date quit____________

Are you currently pregnant, or plan on a pregnancy in the next six months? ____ No ____ Yes

Current Medical Illness and/or Past Major Surgeries:____

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Review of Systems: ***Circle any that are appropriate***

Constitutional: Weight Loss, Fever, Fatigue, Weakness

Eyes: Double Vision, Loss of Vision, Blind Spots, Cataracts

Ear, Nose, Throat: Nosebleeds, Gum Disease, Hoarseness, Difficult Swallowing

Cardiac: High Blood Pressure, Chest Pain, Shortness of Breath, Murmurs, Previous Heart Attack, Heart Failure, Rheumatic Fever

Respiratory: Coughing up blood, Sputum Production, Emphysema, Wheezing Tuberculosis, Pneumonia

GI: Ulcer Disease, Heartburn, Liver Disease, Black Stool, Jaundice, Hepatitis

Musculo-Skeletal: Cramps with Walking, Varicose Veins, Joint Injuries, Arthritis, Swelling in Legs and/or Feet, Gout, Numbness

Skin: Rashes, Cuts, Cancers

Neurological: Strokes, Dizziness, Tremors, Headache, Seizures, Transient, Blindness, and Loss of Arm or Leg Function, Alzheimer's, Dementia

Psychiatric: Anxiety, Depression, Sleep Disturbance, Hallucinations

Endocrine: Thyroid Disorder, Elevated Cholesterol, Diabetes

Hematological/Lymphatic: Prior Cancer, Prior Blood Transfusion, Bleeding Problems, Blood Clots

Allergy/Immunologic: Healing Problems, HIV Disease