You currently reside? ☐ Independently ☐ Assisted Living Facility ☐ Nursing Home

Review of Systems

Please indicate any symptoms you are currently experiencing

Const

Recent weight loss/gain # of pounds _____

☐ Fever ☐ Chills ☐ Poor appetite
☐ Fatigue ☐ Insominia ☐ Night sweats

Eyes

☐ Wear glasses/contact lenses ☐ Eye pain
☐ Decrease in vision ☐ Double vision ☐ Blurry vision
☐ Eye discharge ☐ Eye redness ☐ Dry eyes

ENMT

☐ Ear pain ☐ Hearing loss ☐ Ear discharge
☐ Nose bleeds ☐ Sinus problems ☐ Sore throat

CV

☐ Chest pain ☐ Palpitation ☐ Irregular pulse
☐ High blood pressure ☐ Pain while at rest
☐ Low blood pressure
☐ Swelling of feet, ankles or hands
How far can you walk without pain? _____

Resp

☐ Chronic or frequent coughs ☐ Wheezing
☐ Shortness of breath while walking ☐ Spitting up blood
☐ Shortness of breath while lying flat

GI

☐ Abdominal pain ☐ Heartburn ☐ Vomiting
☐ Diarrhea ☐ Constipation ☐ Vomiting blood
☐ Hemorrhoids ☐ Stomach ulcer ☐ Jaundice
☐ Rectal bleeding or blood in stool ☐ Trouble swallowing
☐ Change in bowel movement or painful bowel movements

Genitourinary

☐ Frequent urination ☐ Urinary Retention ☐ Blood in urine
☐ Burning or painful urination
☐ Incontinence or dribbling ☐ Male - testicle pain
☐ Change in force of stream when urinating

Skin

☐ Rash or itching ☐ Breast pain ☐ Breast lump
☐ Nail changes ☐ Mole changes ☐ Hair loss

Musculo

☐ Joint pain ☐ Muscle weakness ☐ Arthritis
☐ Frequent leg cramps ☐ Cold extremities ☐ Back pain
☐ Muscle pains or cramps (aches) ☐ Joint swelling

Psych

☐ Memory loss/confusion ☐ Panic Attacks
☐ Depressed mood ☐ Nervousness/Anxiety

Neuro

☐ Headaches ☐ Light headed or dizzy
☐ Loss of balance ☐ Numbness ☐ Tingling sensation
☐ Paralysis ☐ Head injury ☐ Slurred speech
☐ Convulsions or seizures

Endocrine

☐ Prescription steroid use ☐ Heat intolerance
☐ Change in skin pigment ☐ Cold intolerance
☐ Excessive thirst ☐ Excessive urination

Hematologic/Lymphatic

☐ Bleeding or bruising tendency ☐ Anemia
☐ Phlebitis or blood clots in legs ☐ Enlarged glands
☐ Chemo treatments currently ☐ Radiation treatments currently

Allergic/Immunic

☐ Frequent infections
☐ Positive tuberculin skin test (TB)

Past Medical History

Please indicate any personal history below, past or present

CV

☐ Heart murmur ☐ Rheumatic fever ☐ Heart disease
☐ Mitral valve prolapse ☐ Varicose veins ☐ Pacemaker/AICD
☐ Poor circulation ☐ Heart surgery ☐ Hypotension
☐ Congenstive Heart Failure (CHF) ☐ Hypertension
☐ Peripheral Vascular Disease (PVD) ☐ Atrial Fibrillation
☐ Coronary angiogram ☐ History of heart attack
☐ Hypercholesterolemia

ENMT

☐ Deaf ☐ Laryngeal Cancer

Eyes

☐ Glaucoma ☐ Cataracts
☐ Blind ☐ Eye surgery

Resp

☐ Sleep apnea ☐ Asthma ☐ Lung Cancer
☐ Bronchitis ☐ Pneumonia
☐ Emphysema or COPD

GI

☐ Cirrhosis/Liver disease ☐ GERD
☐ Hepatitis ☐ History of Diverticulitis
☐ Crohn's disease ☐ Lynch Syndrome / HNPCC
☐ Ulcerated Colitis ☐ Esophageal Cancer
☐ History of colon / rectal cancer ☐ Constipation

Genitourinary

☐ Frequent UTI's ☐ Kidney stones ☐ Kidney disease
☐ Kidney Failure - Hemo Dialysis or CAPD ☐ Ovarian Cancer
☐ Tubal ligation ☐ Hysterectomy ☐ Uterine Cancer
Date of last PSA? _____

Skin

☐ Breast discharge ☐ History of Breast Cancer
☐ Skin sores ☐ Psoriasis ☐ Eczema
Date of last Mammogram? _____ ☐ Skin Cancer

Musculo

☐ Rheumatoid arthritis ☐ Hernia
☐ Fibromyalgia ☐ Degenerative Disc Disease
☐ Osteoarthritis

Psych

☐ Insomnia ☐ Bipolar disease ☐ Anxiety
☐ Depression ☐ Schizophrenia

Neuro

☐ Vertigo ☐ Brain tumor ☐ Migraines
☐ Tremors ☐ Stroke ☐ TIA

Endocrine

☐ Thyroid disease ☐ Goiter
☐ Diabetes - oral medication
☐ Diabetes - insulin

Hematologic/Lymphatic

☐ Cancer ---- Type? _____
☐ Past transfusion-blood/plasma

Allergic/Immunic

☐ Hepatitis ☐ HIV +

Authorization & Release

To the best of my knowledge, the questions in this packet (pages 1-3) have been accurately answered. I understand that providing incorrct 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 authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ Date: _____