

REVIEW OF SYSTEMS: Please ✓ any of the items that apply to you or that you may be experiencing.

CHIEF COMPLAINT: Please explain in your own words, the reason you are here today.

GENERAL HISTORY

Normal Weight: _____

Recent Weight Loss
Amount: _____

Recent Weight Gain
Amount: _____

- Loss of appetite
- Fatigue
- Weakness
- Fevers
- Chills
- Night sweats
- Sleep problems

EYES

- Glasses
- Contact Lenses
- Glaucoma
- Cataracts
- Double vision
- Change in vision
- Other vision problems

EARS/NOSE/THROAT

- Loss of hearing
- Hearing aid
- Ringing in ears
- Other ear problems
- Dentures
- Dental problems
- Frequent sore throats
- Hoarseness
- Difficulty swallowing
- Dry mouth
- Loss of taste
- Neck stiffness
- Neck pain or swelling

CARDIOVASCULAR

- Pacemaker
- Chest pain
- Irregular heartbeat
- Palpitations
- Hypertension
- Sleep sitting or propped up
- Short breath when lying down
- Fainting spells
- Leg pain while walking
- Swelling in feet
- Varicose veins
- Oxygen use at home

RESPIRATORY

- Shortness of breath
- Difficulty breathing

PAIN

Do you currently have any pain? Yes No If yes, where? _____

Please circle your current pain level on a scale of 0-10 (0 being no pain and 10 being the worst pain, or intolerable).

0	1	2	3	4	5	6	7	8	9	10
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Do you take medication for this pain? Yes No List: _____

Is this medication effective for your pain? Yes No

- Coughing
- Dry cough
- Coughing up sputum
- Coughing up blood

GASTROINTESTINAL

- Heartburn
- Nausea/upset stomach
- Abdominal pain
- Vomiting
- Jaundice
- Change in bowel habits
- Constipation
- Diarrhea
- Blood in stool
- Hemorrhoids/fissures
- Colonoscopy Date of Last: _____

GENTOURINARY

- Difficulty urinating
- Frequent urination
- Painful urination
- Up at night to pass urine
- Blood in urine
- Color change of urine

WOMEN ONLY

Age of Menarche ___ Age of Menopause ___

Date of last menstrual period: _____

Date of last pelvic exam: _____

Date of last pap: _____

Oral Contraceptives: Current Past

- Abnormal vaginal bleeding
- Hot flashes
- Hormone therapy
- Currently sexually active

Is there a chance you may be pregnant?

Yes No

___# of pregnancies ___# living

MEN ONLY

- Impotence
- Difficulty with erections
- Penile discharge
- Testicular mass
- Testicular pain

MUSCULOSKELETAL

- Leg cramps
- Painful muscles
- Painful joints
- Artificial joints
- Physical disabilities
- Gout

SKIN & BREAST

- Itching
- Blotch
- Rash
- Scaling
- Sores
- Color changes
- Pain in breast
- Growths
- Lump or mass in breast or armpit
- Discharge or bleeding from nipple
- Change in nipple
- Nipple inversion
- Change in size, shape or contour of breast
- Mammogram Date of Last: _____

NEUROLOGICAL

- Headaches
- Tremors
- Memory loss
- Difficulty finding words
- Difficulty writing
- Difficulty thinking clearly
- Numbness or tingling
- Dizziness
- Loss of consciousness
- Seizures
- Coordination
- Unsteady gait

PSYCHIATRIC

- Nervousness
- Anxiety
- Depression
- Change in personality
- Relationship problems

ENDOCRINE

- Excessive thirst
- Excessive urination
- Thyroid problems

HEMATOLOGIC & LYMPHATIC

- Swollen lymph glands
- Excessive bruising
- Excessive bleeding

ALLERGY & IMMUNOLOGY

- Medications
- Latex allergies
- Food or non-medication allergies
- Tape allergies
- Hay Fever
- None