Patient Name_____

Review of Systems

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle/ Joint/ Bone

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

Genito-Urinary

- Blood in Urine
- Frequent urination
- Lack of bladder control
- Painful urination

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach Pain
- Vomiting
- Vomiting blood

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of an ankle
- Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nose bleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

Men only

- Breast Lump
- Erection difficulties
- Lump in testicles
- Penile discharge
- Sore on Penis
- Other

Women Only

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge

Date of last menstrual Period_____
Date of last Pap Smear_____
Have you had a mammogram?_____
Are you pregnant?_____
Number of children____

Medical/ Social History

Have you ever had any surgery in the past? Yes No
Have you experienced surgical related problems? Yes No

Do you have a history of?: Hepatitis HIV Blood Transfusion

Do you have a family history of?:

Heart Disease, Strokes	Yes	No	Bleeding Disorders	Yes	No	Asthma, Hay Fever	Yes	No
Diabetes	Yes	No	Arthritis, Gout	Yes	No	Cancer	Yes	No
Rheumatoid Arthritis	Yes	No	Muscular Dystrophy	Yes	No	Chemical Dependency	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No

Tobacco Use? Cigarettes
Alcohol Use? Current
Drug Use? Previous
Oral
Cigars
Smokeless/ Chewing
Drinks/day_____
Smoking last
If so, how much?:_____
Last used:_____
What drug?:_____

- Injection used:_____