Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

EYES

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ 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 problems or rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes
Palpitation	☐ No	☐ Yes
Shortness of breath walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles or hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ 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

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ 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: _____

MUSCULOSKELETAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes

INTEGUMENTARY (skin, breast)

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Head injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ 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
Change in hat or glove size	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ 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:

Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narcotics	☐ No	☐ Yes
Novocain or other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, merthiolate or other antiseptics	☐ No	☐ Yes

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect 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 also authorize the healthcare staff to perform the necessary services I may need.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Review: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Doctor Date

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