

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS-** Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function.

Check either **I DENY having/had** OR **Circle P for PAST** OR **Circle N for NOW**

**CONSTITUTIONAL**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** chills
- P N** daytime drowsiness
- P N** fatigue
- P N** fever
- P N** night sweats
- P N** weight gain
- P N** weight loss

**EYES**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Wear glasses or contact lenses
- P N** blindness
- P N** Cataracts
- P N** Glaucoma

**EARS / NOSE / THROAT**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Difficulty/Loss of hearing
- P N** Ringing in the ears (tinnitus)
- P N** Frequent ear aches
- P N** Discharge from the ear
- P N** Attacks of vertigo
- P N** Sinus trouble
- P N** Nasal blockage
- P N** Frequent sneezing
- P N** Frequent sore throat
- P N** Snoring
- P N** Recent change in voice quality
- P N** Sleep apnea
- P N** Difficulty in swallowing
- P N** Nose bleeds

**RESPIRATORY**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Asthma or wheezing
- P N** Recent bronchitis or chest cold
- P N** Cough
- P N** Coughing up blood
- P N** Shortness of breath

**HEART & CIRCULATION**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Heart attack
- P N** High blood pressure
- P N** Heart murmur
- P N** Chest discomfort (angina)
- P N** Heart failure or fluid on the lungs
- P N** Palpitations, racing or pounding
- P N** Shortness of breath w/activity
- P N** Stroke / mini stroke or TIA

- P N** Blood clot in artery or vein
- P N** "Black out spells"
- P N** Aneurysm of any blood vessel
- P N** Swelling of legs
- P N** Heart surgery
- P N** Heart palpitations

**STOMACH / INTESTINES**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Ulcer
- P N** Frequent heartburn or indigestion
- P N** Hiatal hernia and or acid reflux
- P N** Poor appetite
- P N** Gall bladder attacks
- P N** Frequent diarrhea
- P N** Chronic constipation
- P N** Bright blood bowels or rectum
- P N** Abnormal stool
- P N** Liver disease or jaundice

**ENDOCRINE / METABOLISM**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Thyroid disorder
- P N** Unusual hair loss or growth
- P N** goiter
- P N** Diabetes

**KIDNEYS / URINARY TRACT**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Kidney disease or failure
- P N** History of kidney dialysis
- P N** Kidney stones or infection
- P N** Pain or burning with urination
- P N** Trouble starting urinary stream
- P N** Dribbling or incontinence
- P N** Frequent Night Urination
- P N** Bladder infections during past year
- P N** Blood in urine during past year

**MUSCLES / BONES / JOINTS**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Arthritis or other joint disease
- P N** Chronic back trouble
- P N** Bone or joint surgery in past year

**ALLERGY**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** anaphylaxis
- P N** food intolerance
- P N** itching
- P N** nasal congestion
- P N** rash
- P N** sneezing

**SKIN**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Rashes, psoriasis or dermatitis
- P N** History of skin cancer
- P N** New skin growth or mole

**NERVOUS SYSTEM**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Headache
- P N** Epilepsy or seizures
- P N** Date of last seizure: \_\_\_\_\_
- P N** Depression
- P N** Other nervous disorder

Specify: \_\_\_\_\_

**PSYCHOLOGIC**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** anxiety
- P N** loss or change in appetite
- P N** behavioral change
- P N** bi-polar disorder
- P N** confusion
- P N** convulsions
- P N** depression
- P N** insomnia
- P N** memory loss
- P N** mood change

**BLOOD**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Bleeding or bruising tendency
- P N** Previous blood transfusion
- P N** History of hepatitis

**MEN ONLY**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Testicular swelling
- P N** Prostate Problems
- P N** Frequent urination

**WOMEN ONLY**

- I DENY** having or having had any of the symptoms or problems listed below.
- P N** Painful periods
- P N** Excessive Flow
- P N** Irregular cycles
- P N** Vaginal Burning
- P N** Hot Flash

Are you pregnant? Yes No

**Past Medical and Family History**

**Surgical History: (NONE)** \_\_\_\_\_

**Hospitalization History: (NONE)** \_\_\_\_\_

**Allergy History: (NONE)** \_\_\_\_\_

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes      Cancer      High Blood Pressure      Allergy      Hearing Loss      Stroke      Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): \_\_\_\_\_

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **BLOOD PRESSURE** \_\_\_\_\_ **PULSE** \_\_\_\_\_  **N/A MINOR**

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_