

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS:

Do you presently have any of the following: (Please check YES or NO)

Change in vision. YES NO
Hoarseness.
Change in swallowing.
Weight Loss (recent).
Rashes.

Do you presently take Medications?
YES NO If yes, what
medication do you take? _____

CARDIOVASCULAR-RESPIRATORY: YES NO
Chronic cough
Chest pain.
Palpitations.
Shortness of breath
Coughing up blood

YES NO
ALLERGIES TO MEDICATION:
If yes, what medications are you
allergic to? _____

GENITOURINARY: YES NO
History bladder infection _____
Pain on urination
Difficulty controlling
urination

HEIGHT _____

WEIGHT _____

OCCUPATION _____

HEMATOLOGIC/LYMPHATIC: YES NO
Bleeding Problems
Frequent nose bleeds.
Easy bruising

SOCIAL HISTORY: YES NO
Do you smoke?
of packs per day.
Duration of smoking history _____
Do you drink liquor?
of drinks per day

GASTROINTESTINAL: YES NO
Change in bowel habits.
Abdominal Pain.
Nausea or vomiting.

PAST MEDICAL HISTORY: YES NO
Heart Attack.
High Blood Pressure
Asthma.
Diabetes.
Thyroid Disease
Cancer.
Type _____

NEUROLOGICAL/PSYCHIATRIC: YES NO
Headaches
Seizures.
Numbness.
Site of numbness _____
Weakness.
Site of weakness _____
Depression.
Anxiety

Ulcers.
Phlebitis/blood clots
Kidney Disease.
Liver Disease/Hepatitis
Stroke.
Other _____

FAMILY HISTORY: YES NO
Diabetes.
Rheumatoid Arthritis.
Gout.
Muscle/Nerve Disorder

Prior Surgeries - *please list*

___ All other systems negative

PHYSICIAN SIGNATURE