REVIEW OF SYSTEMS

Check conditions you currently have, are currently being treated for, or have had in the past year:

Date of last physical exam: ______________

RESPIRATORY

- ☐ Sleep apnea
- ☐ Coughing up blood
- ☐ Night cough
- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Chronic Obstructive Pulmonary Disease (C.O.P.D.)
- ☐ Tuberculosis (T.B.)
- ☐ Lung Cancer
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Other ______________________

GASTROINTESTINAL

- ☐ Change in bowel habits
- ☐ Ulcer (stomach or duodenal)
- ☐ Irritable bowel
- ☐ Colitis
- ☐ Blood in stool or rectal bleeding
- ☐ Black tarry stool
- ☐ Heartburn
- ☐ Vomit up blood
- ☐ Nausea
- ☐ Vomiting
- ☐ Gastroesophageal Reflux Disease (G.E.R.D.)
- ☐ Dry mouth
- ☐ Pain on swallowing
- ☐ Difficulty in swallowing
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Hemorrhoids
- ☐ Liver disease
- ☐ Stomach, bowel or colon cancer
- ☐ Diverticulitis/Diverticulosis
- ☐ Other ______________________

ENDOCRINE

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Increased thirst or urination
- ☐ Thyroid disease
- ☐ Intolerance to heat or cold
- ☐ Goiter
- ☐ Pancreatic cancer
- ☐ Other ______________________

CONSTITUTIONAL

- ☐ Weight loss or gain (circle one) greater than 10 pounds in the last 6 months
- ☐ Loss of appetite
- ☐ Fever greater than 100° F
- ☐ Night sweats
- ☐ Chills
- ☐ Fatigue
- ☐ Other ______________________

EYES

- ☐ Glasses/contact lenses
- ☐ Glaucoma
- ☐ Dry eyes
- ☐ Double or blurred vision
- ☐ Astigmatism
- ☐ Cataract(s)
- ☐ Eye disease or injury
- ☐ Other ______________________

CARDIOVASCULAR

- ☐ Congestive Heart Failure (CHF)
- ☐ High blood pressure
- ☐ Angina or chest pain
- ☐ Irregular heart beat
- ☐ Heart valve disease
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Varicose veins
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Coronary artery disease
- ☐ Palpitations
- ☐ Shortness of breath while walking
- ☐ Swelling of feet, ankles or hands {circle which one(s)}
- ☐ Pacemaker/A.E.D.
- ☐ Other ______________________

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Low back pain
- ☐ Neck pain
- ☐ Other ______________________

CONTINUED ON REVERSE SIDE

INTEGUMENTARY

- ☐ Breast lump
- ☐ Breast discharge
- ☐ Date of last mammogram _________
- ☐ Skin cancer
- ☐ Breast cancer
- ☐ Melanoma
- ☐ Sore that won't heal
- ☐ Rash
- ☐ Change in moles
- ☐ Itching
- ☐ Hives
- ☐ Bruise easily
- ☐ Tattoos
- ☐ Body piercings other than ears
- ☐ Other _________________________

GENITOURINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Kidney or bladder stones
- ☐ Sexually transmitted disease(s) (STD)
- ☐ Change in force or straining when urinating
- ☐ Dribbling or incontinence
- ☐ Bladder or kidney cancer
- ☐ Other _________________________

FEMALE:

- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Irregular periods
- ☐ Number of pregnancies ___________
- ☐ Number of miscarriages ___________
- ☐ Number of abortions ____________
- ☐ Date of last pap smear ___________
- ☐ Uterine or cervical cancer
- ☐ Ovarian cancer
- ☐ Other _________________________

MALE:

- ☐ Prostate problem
- ☐ Erection difficulty
- ☐ Testicle pain
- ☐ Penile discharge
- ☐ Other _________________________

HEMATOLOGICAL/ONCOLOGICAL

- ☐ Anemia
- ☐ Cancer – what kind _______________
- ☐ Past blood or blood product transfusion
- ☐ Lymph node enlargement (swollen glands)
- ☐ Bleeding (hemophilia)
- ☐ Leukemia or blood cancer

NEUROLOGICAL

- ☐ Migraines
- ☐ Frequent or recurring headaches
- ☐ Dizzy (room spins)
- ☐ Parkinson's
- ☐ Seizures, if yes, date of last one ____________
- ☐ Concussion or head injury
- ☐ Difficulty speaking
- ☐ Numbness in face, arms, legs or feet {circle which one(s)}
- ☐ Stroke
- ☐ Epilepsy
- ☐ Transitory Ischemic Attack (TIA)
- ☐ Tremors
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Brain cancer
- ☐ Other ___________________________

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Increased stress level
- ☐ Bipolar disease
- ☐ Suicidal
- ☐ Hallucinations
- ☐ Light affective disorder
- ☐ Chemical dependency – alcohol or drugs
- ☐ Memory loss or confusion
- ☐ Insomnia (can't sleep)
- ☐ Other _______________________________

ALLERGIC/IMMUNOLOGICAL

- ☐ Problems with anesthetics local or general
- ☐ HIV Positive
- ☐ Herpes
- ☐ Lupus
- ☐ Scleroderma
- ☐ Other _______________________________
- ☐ Allergy to medicine, foods or environmental factors
  Please list: ___________________________

____

____

____

____

____

____