Review of Systems

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Date:____________________________

Patient Name:___________________________________ Date of Birth:__________________________

To help your physician better evaluate your medical condition, please provide the following information:
***If you will bring any interval lab/test results with you to your appointment, it will speed up your visit as we will not have to call and wait for these reports or duplicate any testing that has recently been performed.*

Have you had any of the following since your last appointment? (date and details):

Hospitalizations and doctor office visits:____

Labs/X-rays/Procedures/Surgery/IV dye for CT/MRI/Ateriogram:____

Are you taking any of the following medications? ☐Ibuprofen ☐Aleeve ☐Advil ☐Naprosyn ☐Motrin ☐Celebrex ☐Sulfa

Have you been immunized? ☐Pneumococcal ☐Influenza ☐Shingles (Zostivx)

Do you currently have any of the following symptoms:

Constitutional	☐Fever ☐Weight gain ☐Weight loss ☐Fatigue ☐Chills ☐Weakness
HEENT	☐Vision impaired ☐Eye pain ☐Double vision ☐Hearing loss ☐Sinus problems ☐Sore throat ☐Nose bleeds ☐Headache
Respiratory	☐Shortness of breath ☐Shortness of breath at rest ☐Shortness of breath with activity ☐Cough ☐Wheezing ☐Blood in sputum ☐Pain with breathing ☐Night sweats
Cardiovascular	☐Chest pain ☐Palpitations ☐Claudication (leg pain w/walking) ☐Orthopnea (trouble lying flat) ☐Edema (swelling) ☐PND (sleep on more than 2 pillows)
Gastrointestinal	☐Abdominal pain ☐Nausea ☐Diarrhea ☐Heartburn ☐Vomiting ☐Constipation ☐Anorexia (loss of appetite) ☐Trouble swallowing ☐Indigestion
Genitourinary	☐Urinary urgency ☐Urinary burning or pain ☐Blood in urine ☐Urinary frequency ☐Urinary hesitancy ☐Foamy urine ☐Incontinency ☐Nocturia (Urinate more than 1 time per night)
Musculoskeletal	☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Arm weakness ☐Leg weakness
Skin	☐Rash ☐Itching ☐Dryness ☐Color change
Neurological	☐Numbness ☐Tremors ☐Seizures ☐Tingling ☐Fainting
Psychiatric	☐Depression ☐Anxiety ☐Insomnia
Endocrine	☐Heat intolerance ☐Excessive thirst ☐Cold intolerance ☐Excessive urination
Hematology	☐Bleeding gums ☐Easy bruising
Immuno/Allergy	☐Seasonal allergies ☐Hives

Social History

Current Marital Status	☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Living arrangement	☐Alone ☐Spouse ☐Significant other ☐Family member ☐In-home caregiver ☐Assisted living facility
Occupation	☐Retired ☐Employed ☐Unemployed ☐Student
Profession	______________________________
Level of Education	______________________________

Habits

Tobacco use	☐Current user ☐Former user ☐Never used Amount__________________
Alcohol use	☐Current user ☐Former user ☐Never used Amount__________________
Recreational drug use	☐Current user ☐Former user ☐Never used