REVIEW OF SYSTEMS

Name _____ Account# _____

The following information is very important to your health. Please take the time to fully and accurately fill out this form according to your current condition.

CONSTITUTIONAL SYMPTOMS

Good general health	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Headaches	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Swelling of feet, ankles, hands	No	Yes
Spitting up blood	No	Yes

MUSKULOSKELETAL

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
Difficulty in walking	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
Stroke	No	Yes
Head injury	No	Yes

GASTROINTESTINAL

Nausea or vomiting	No	Yes
Rectal bleeding/blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

MEDICAL HISTORY

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes
Arthritis/Gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal disease	No	Yes
Hereditary disease	No	Yes
HIV	No	Yes

The above information is true and correct to the best of my belief.

_____
Patient's Signature Date

GENITOURINARY

Frequent urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes

ENDOCRINE

Excessive thirst or urination	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Enlarged glands	No	Yes

RESPIRATORY

Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Chronic or frequent coughs	No	Yes

PREVIOUS HOSPITALIZATION - ANY No Yes

IF YES LIST: _____

_____

PREVIOUS SURGERIES - ANY No Yes

IF YES LIST: _____

_____

FAMILY DISEASES AND RELATIONSHIP

_____

SOCIAL HISTORY

Alcohol use:
_____ Never _____ Rarely _____ Moderate _____Daily

Tobacco use:
_____ Never _____ Daily _____ Previously but quit

Drug use:
_____ Never _____ Rarely _____ Daily _____Type

_____
Physician's Signature Date