REVIEW OF SYSTEMS:

Please circle any that apply to your health.

Constitutional Symptoms
Recent Weight Change
Fever
Fatigue
Headaches

Eyes
Eye disease or injury
Wear glasses/contact lenses
Blurred or double vision

Ears/Nose/Mouth/Throat
Hearing loss or ringing
Earaches or drainage
Chronic sinus problem
Nose bleeds
Mouth sores
Bleeding gums
Bad breath/Bad taste
Sore throat/Voice change
Swollen glands in neck

Cardiovascular
Heart trouble
Chest pain or angina pectoris
Palpitation
Shortness of breath
Swelling of feet, ankles or hands

Respiratory
Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal
Loss of appetite
Change in bowel movements
Nausea or vomiting
Frequent diarrhea
Painful bowel movements or constipation
Rectal Bleeding or blood in stool
Abdominal pain

Genitourinary
Frequent urination
Burning or painful urination
Blood in urine
Change in force of strain when urinating
Incontinence or dribbling
Kidney stones

Sexual difficulty
Male – testical pain
Female – painful periods
Female - Irregular periods
Female – Vaginal discharge
Female - # of pregnancies
Female - # of miscarriages
Female – Date of last pap smear

Musculoskeletal
Joint Pain
Joint stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back Pain
Cold Extremities
Difficulty in Walking

Integumentary (Skin/Breast)
Rash or itching
Change in skin color
Change in hair or nails
Vericose veins
Breast pain
Breast Lump
Breast Discharge

Neurological
Frequent or recurring headaches
Lightheaded or dizzy
Convulsion or seizures
Numbness/Tingling sensations
Tremors
Paralysis
Head injury

Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia

Endocrine
Glandular or Hormone Problem
Excessive thirst or urination
Heat or cold intolerance
Skin becoming dryer
Change in hat or glove size

Hemotologic/Lymphatic
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Phlebitis
Past transfusion
Enlarged glands

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics
- Morphine or other narcotics
- Novocain or other anesthetics
- Aspirin or other pain remedies
- Tetanus or other serums
- Iodine or other antiseptic
- Sulpha Drugs

Other drugs/medications: ______________
____
____

Known food allergies: _________________
____
____

Environmental allergies: _______________
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctors office in any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

___________________________________ ___________________
Signature of Patient, Parent or Guardian Date

DOCTORS REVIEW:

___________________________________ ___________________
Signature of Doctor Date

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