

Patient Name \_\_\_\_\_  
FIRST MI LAST

Birthdate \_\_\_\_\_

### Review of Systems: Please indicate any personal history below.

#### CONSTITUTIONAL SYMPTOMS

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

#### EYES

Eye disease or injury  No  Yes  
Wear glasses/contact lenses  No  Yes  
Blurred or double vision  No  Yes  
Last eye exam \_\_\_\_\_

#### EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing  No  Yes  
Earaches or drainage  No  Yes  
Chronic sinus problems or rhinitis  No  Yes  
Nose bleeds  No  Yes  
Mouth sores  No  Yes  
Bleeding gums  No  Yes  
Bad breath or bad taste  No  Yes  
Sore throat or voice change  No  Yes  
Swollen glands in neck  No  Yes

#### CARDIOVASCULAR

Heart trouble  No  Yes  
Chest pain or angina pectoris  No  Yes  
Palpitation  No  Yes  
Shortness of breath walking or lying flat  No  Yes  
Swelling of feet, ankles or hands  No  Yes

#### RESPIRATORY

Chronic or frequent cough  No  Yes  
Spitting up blood  No  Yes  
Shortness of breath  No  Yes  
Wheezing  No  Yes

#### GASTROINTESTINAL

Loss of appetite  No  Yes  
Change in bowel movement  No  Yes  
Nausea or vomiting  No  Yes  
Light headed or dizzy  No  Yes  
Frequent diarrhea  No  Yes  
Painful bowel movements or constipation  No  Yes  
Rectal bleeding or blood in stool  No  Yes  
Abdominal pain  No  Yes

#### GENITOURINARY

Frequent urination  No  Yes  
Burning or painful urination  No  Yes  
Blood in urine  No  Yes  
Change in force of strain  No  Yes  
When urinating  
Incontinence or dribbling  No  Yes  
Kidney stones  No  Yes  
Sexually transmitted disease  No  Yes  
Sexual difficulty  No  Yes  
Male - testicle pain  No  Yes  
Female - pain with periods  No  Yes  
Female - abnormal paps  No  Yes  
Female - irregular periods  No  Yes  
Female - vaginal discharge  No  Yes  
Female - # of pregnancies \_\_\_\_\_  
Female - # of miscarriages \_\_\_\_\_  
Female - date of last pap smear \_\_\_\_\_  
Female - date of last menstrual period \_\_\_\_\_  
Female - age of first period \_\_\_\_\_

#### MUSCULOSKELETAL

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  
Cold extremities  No  Yes  
Difficulty walking  No  Yes

#### INTEGUMENTARY (SKIN, BREAST)

Rash or itching  No  Yes  
Change in skin color  No  Yes  
Change in hair or nails  No  Yes  
Varicose veins  No  Yes  
Breast pain  No  Yes  
Breast lump  No  Yes  
Breast discharge  No  Yes

#### NEUROLOGICAL

Frequent or recurring  No  Yes  
Headaches  No  Yes  
Convulsions or seizures  No  Yes  
Numbness or tingling  No  Yes  
Sensation  
Tremors  No  Yes  
Paralysis  No  Yes  
Head injury  No  Yes

#### PSYCHIATRIC

Memory loss  No  Yes  
Nervousness  No  Yes  
Depression  No  Yes  
Insomnia  No  Yes

#### ENDOCRINE

Glandular or hormone Problems  No  Yes  
Excessive thirst or Urination  No  Yes  
Heat or cold intolerance  No  Yes  
Skin becoming drier  No  Yes  
Change in hat or glove size  No  Yes

#### HEMATOLOGIC/LYMPHATIC

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

#### ALLERGIC/IMMUNOLOGIC

History of skin/ other reaction to:  
Penicillin  No  Yes  
Morphine, Demerol, or other narcotics  No  Yes  
Novocain or other  No  Yes  
Anesthetic  No  Yes  
Aspirin or other pain Remedies  No  Yes  
Tetanus, antitoxin, or other serums  No  Yes  
Iodine, methiolate, or other antiseptics  No  Yes  
Other drugs/medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Known food allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Environmental allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### AUTHORIZATION & RELEASE

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 doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X \_\_\_\_\_  
Signature of patient (or parent if minor)

Date \_\_\_\_\_

Provider's Review/comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_