Patient Name_____ Birthdate_____
FIRST MI LAST

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

GENITOURNARY
Frequent urination __No__Yes
Burning or painful urination __No__Yes
Blood in urine __No__Yes
Change in force of strain When urinating __No__Yes
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 Headaches __No__Yes
Convulsions or seizures __No__Yes
Numbness or tingling Sensation __No__Yes
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 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_____ Date_____
Signature of patient (or parent if minor)

Provider's Review/comments:_____
_____
_____
_____
_____
Signature of Provider Date