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
Kidney stones.....NO YES

□ Eyes

Eye disease or injury..... NO YES
Wear glasses/contact lenses ..... NO YES
Blurred or double vision .....NO YES

□ Ears/Nose/Mouth/Throat

Hearing loss or ringing..... NO YES
Earaches or drainage..... NO YES
Chronic sinus problem or rhinitis... NO YES
Nosebleeds..... 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 w/walking or lying
Flat .....NO YES
Swelling of feet, ankles or hands...NO YES

□ Respiratory

Chronic or frequent coughs .....NO YES
Spitting up blood..... NO YES
Shortness of breath.....NO YES
Wheezing.....NO YES

□ Gastrointestinal

Loss of appetite.....NO YES
Change in bowel movements ..... NO YES
Nausea or vomiting .....NO YES
Frequent diarrhea..... NO YES
Painful bowel movements or
constipation.....NO YES
Rectal bleeding or blood in stool NO YES

□ GENITOURINARY

Frequent Urination.....NO YES
Burning or painful urination.....NO YES
Blood in urine .....NO YES
Change in urination strain .....NO YES
Incontinence or dribbling.....NO YES
Sexual Difficulty.....NO YES
Male-Testicular Pain .....NO YES
Female- Pain with periods.....NO YES
Female- Vaginal Discharge.....NO YES
Change in hat or glove size.....NO YES
Female- # of miscarriages ..... _____
Female-date of last paper smear _____
Female- # of pregnancies ..... _____

□ 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 in 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
Light headed or dizzy .....NO YES
Convulsions or seizures.....NO YES
Numbness or tingling sensations ..... NO YES
Tremors .....NO YES
Paralysis .....NO YES
Head injury .....NO YES
When _____

□ PSYCHIATRIC

Memory loss or confusion.....NO YES
Nervousness .....NO YES
Depression..... NO YES
Insomnia.....NO YES

□ Endocrine

Glandular or hormone problem....NO YES
Excessive thirst or urination..... NO YES
Heat or cold intolerance ..... NO YES
Skin becoming dryer.....NO YES
Change in hat or glove size.....NO YES

□ Hematologic/Lymphatic

Slow to heat after cuts.....NO YES
Bleeding or bruising tendency.....NO YES
Anemia.....NO YES
Phlebitis.....NO YES
Past Transfusion.....NO YES
Enlarged Glands.....NO YES

□ Allergic/Immunologic

History of skin reaction or other adverse reaction to:
Penicillin/anti-biotics .....NO YES
Morphine, Demerol or other narcotics..NO YES
Novocain or anesthetics.....NO YES
Aspirin or pain remedies.....NO YES
Tetanus antitoxin or other serums.....NO YES
Iodine, Merthiolate Or antiseptic .....NO YES

Other drugs/Meds:
_____
_____

Food Allergies:
_____
_____

Environmental Allergies:
_____
_____

To the best of my knowledge, he questions in 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.

Signature of Patient or Parent/Guardian _____ Date _____

Signature of Doctor_____ Date_____