Review of Systems

SKIN

☐ Rashes, psoriasis or dermatitis

☐ Non-healing sores or skin ulcerations

EYES

☐ Wear glasses

☐ Wear contact lenses

☐ Permanent blindness in either eye

☐ Cataracts

☐ Glaucoma

HEART

☐ Heart Attack

What year? ____

☐ Chest discomfort/ angina with physical activity

☐ Chest discomfort/angina at rest

☐ Shortness of breath with exertion

☐ Shortness of breath at rest

☐ Waking at night gasping for air or short of breath

☐ Require more than one pillow at night to breathe well

☐ Heart failure or "Fluid on lungs"

☐ Palpitations, racing or pounding heart beat

☐ Pauses in the heart beat

☐ Previously diagnosed heart rhythm disturbance

☐ Heart Murmur

EARS/NOSE/THROAT

☐ Loss of hearing

(Hearing aids) □ Yes □ No

☐ Ringing in the ears

☐ Frequent ear infections or discharge

☐ Frequent or severe nose bleeds

☐ Nasal Polyps

☐ Frequent sinus infections

☐ Frequent sore throats

☐ Dentures

☐ Loose teeth

LUNGS

☐ Asthma or wheezing

☐ Recent bronchitis or chest

☐ Pneumonia

☐ Emphysema

☐ Tuberculosis

☐ Chronic cough

☐ Coughing up blood

☐ Exposure to asbestos

☐ Blood clot (embolus) to lungs

CIRCULATION

	Right	Left	Both
☐ Discoloration	☐	☐	☐
☐ Waking at night with pain or numbness in feet	☐	☐	☐
☐ Pain in legs or buttocks with exercise	☐	☐	☐
☐ Sores or ulcers on feet or legs	☐	☐	☐
☐ Infection of feet or legs	☐	☐	☐
☐ Blood clot in leg vein	☐	☐	☐
☐ Blood clot in artery	☐	☐	☐
☐ Ankle or leg swelling	☐	☐	☐
☐ Phlebitis in leg veins	☐	☐	☐

☐ Mitral Valve prolapse

BLOOD

☐ Bleeding or bruising tendency

☐ Blood disorder

Specify: _____

☐ Previous blood transfusion

☐ Recent fever

☐ History of Hepatitis or other communicable disease

☐ Large, discolored or varicose veins in legs	☐	☐	☐
☐ Temporary blindness in either eye	☐	☐	☐
☐ Sudden visual disturbances in either eye	☐	☐	☐
☐ Weakness/paralysis of one side of the body	☐	☐	☐
☐ Temporary speech loss or difficulty talking	☐	☐	☐
☐ ”Mini-Strokes” or TIA’s	☐	☐	☐
☐ Stroke	☐	☐	☐
☐ Dizziness, light-headedness or “black out spells”	☐	☐	☐
☐ Aneurysm of any blood vessels	☐	☐	☐

STOMACH/ INTESTINES

☐ Stomach ulcer or peptic ulcer

☐ Trouble swallowing foods or liquids

☐ Frequent heartburn or indigestion

☐ Hiatal Hernia & Reflux

☐ Liver disease or jaundice

What year: _____

☐ Gall bladder attacks

☐ Frequent diarrhea

☐ Chronic constipation

☐ Bright blood from bowels or rectum

☐ Dark, Tarry stools

_____

KIDNEYS/ URINARY TRACT

☐ Kidney disease or failure

☐ History of kidney dialysis

What year? ____

☐ Kidney stones or infection

☐ Pain or burning with urination

☐ Trouble starting urinary stream

☐ Dribbling or incontinence

☐ Multiple trips to bathroom to urinate at night

☐ Bladder infections during past year

☐ Blood in urine during past year

☐ Enlarged prostate

☐ Prostate infections

MUSCLES/BONES/JOINTS

☐ Arthritis or other joint disease

☐ Chronic back trouble

☐ History of broken bones

☐ TMI syndrome

☐ Curvature of the spine

REPRODUCTIVE (Female)

Are you or might you be pregnant?

☐ Yes ☐ No

Last L.M.P? _____

REPRODUCTIVE (Male)

Have you had a Vasectomy?

☐ Yes ☐ No

NERVOUS SYSTEM

☐ Frequent headaches or migraines

☐ Epilepsy or seizures

Date of last seizure: _____

☐ Depression

☐ Nervous disorder

Specify: _____

METABOLISM/ENDOCRINE

☐ Thyroid disorder

☐ Gout

☐ Recent weight gain or loss (>10lbs.)

Activity Level-

Which of the following describes your level of physical activity both in your daily life and your leisure time?

☐ Exercise strenuously on a regular basis

☐ Exercise moderately on a regular basis

☐ Exercise on an occasional basis

☐ Do not regularly exercise, but have an active lifestyle

☐ Have difficulty accomplishing light chores of daily living

☐ Require assistance to accomplish self-care

FAMILY HISTORY-Please list which family member (Immediate Relative) have experience these conditions

Heart Attack: _____ Age: _____
_____ Age: _____
_____ Age: _____
Stroke: _____ Age: _____
_____ Age: _____
_____ Age: _____
Sudden Death: _____ Age: _____
_____ Age: _____

Aneurysm: _____
Diabetes: _____
Cancer: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Failure: _____
Arteriosclerosis: _____
(hardening of the arteries)

If your parents are deceased, please indicate the cause of death and age of death:

Father: _____ Cause of death: _____ Age at death: _____

Mother: _____ Cause of death: _____ Age at death: _____

Do you have any other special concerns or additional information we should be aware of regarding your care?

_____

_____

Please sign below after you have completed this form to the best of your ability and knowledge:

_____ Date: _____