Review Of Systems

Patient Name: _____ Date of Birth: _____Today's Date: _____

Where do you currently reside? (circle one) Independently In an Assisted Living Facility In a Nursing Home

Gastrointestinal

Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Food sticking in throat	No	Yes
Painful swallowing	No	Yes
Vomiting blood	No	Yes
Black Stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Early satiety (feeling full fast)	No	Yes
Bloating	No	Yes

Constitutional

Recent weight gain # of pounds _____	No	Yes
Recent weight loss #of pounds _____	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Neurological

Seizures	No	Yes
Headaches	No	Yes
Loss of memory	No	Yes
Light-Headedness	No	Yes
Fainting	No	Yes
Sinus Issues Location: _____	No	Yes

Dermatology

Rash	No	Yes
Dimpled/orange peel breast	No	Yes

HEENT

Sore throat	No	Yes
Hoarseness	No	Yes
Loss of taste	No	Yes
Loss of balance	No	Yes
Loss of hearing	No	Yes
Pain in ears	No	Yes
Ringing in ears	No	Yes
Buzzing in ears	No	Yes
Dizziness	No	Yes
Vision Issues	No	Yes

Cardiovascular

Abnormal heart rhythm	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes

Respiratory

Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes

Genitourinary

Frequent urination	No	Yes
Kidney failure/dialysis	No	Yes
Painful urination	No	Yes
Date of last menstrual period _____		
Hypoglycemia	No	Yes

Psychiatric

Dementia	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Irritable	No	Yes

Past Surgical History

Abdominal Surgery What type _____	No	Yes
Appendectomy	No	Yes
Cancer Surgery What type _____	No	Yes
Coronary Artery Bypass (CABG)	No	Yes
Coronary Stent	No	Yes
Cosmetic Surgery What type_____	No	Yes
Defibrillator If yes, we need a copy of the card	No	Yes
Gallbladder Removal	No	Yes
Heart Valve Replacement	No	Yes
Hemorrhoid Removal	No	Yes
Hip, Shoulder, Knee replace-ment within 1 year	No	Yes
Hysterectomy (TAH)	No	Yes
Laparoscopy	No	Yes
Pacemaker	No	Yes
Salpingoophorectomu (BSO) (Tube and Ovary removal)	No	Yes
Tonsillectomy	No	Yes
Vascular Bypass/grafts within 1 yr.	No	Yes

Hospitalizations (non-Surgical) & Date

_____

_____

_____

Patient Name: _____ Date of Birth: _____Today's Date: _____

Medical History

Ascites (extra fluid in abdomen)	No	Yes
Asthma	No	Yes
Bleeding Disorder	No	Yes
Cancer What type _____	No	Yes
Congestive Heart Failure (CHF)	No	Yes
Coronary Artery Disease (CAD)	No	Yes
Depression	No	Yes
Diabetes	No	Yes
Emphysema or COPD	No	Yes
Endometriosis	No	Yes
Gallstones	No	Yes
Heart Arrhythmia (A. Fib/SVT/A Flutter)	No	Yes
Heart Attack	No	Yes
Hepatitis	No	Yes
High Blood Pressure	No	Yes
Kidney Failure	No	Yes
Kidney Stones	No	Yes
Liver Disease	No	Yes
Migraine Headaches	No	Yes
Pancreatitis	No	Yes
Peripheral Vascular Disease	No	Yes
Rheumatic Fever	No	Yes
Seizures	No	Yes
Sleep Apnea	No	Yes
Stomach Ulcer	No	Yes
Stroke/TIA	No	Yes
Thyroid Disease	No	Yes
Valvular Heart disease or Endocarditis	No	Yes

Family Medical History (not you) If Yes, please list the relative and age

Colon Cancer	No	Yes	_____
Colon Polyps	No	Yes	_____
Inflammatory Bowel Disease (IBD)	No	Yes	_____
Cancer of:			
Endometrial	No	Yes	_____
Esophagus	No	Yes	_____
Kidney	No	Yes	_____
Ovarian	No	Yes	_____
Pancreas	No	Yes	_____
Small Bowel	No	Yes	_____
Stomach	No	Yes	_____

Social History

Marital Status:	Single _____	Married _____	Separated _____	
	Divorced _____	Widowed ____		
Children:	No _____	Yes _____	How Many _____	
Use of Alcohol:	None _____	Yes _____	How Much _____	
Used of Tobacco:	Never _____	Quit _____	Yes _____	How Much ___
Caffeine Use:	No_____	Yes _____		
Sleep:	Hours _____			

Drug Allergies/ Intolerance	Current Medications/Doses

Are you taking any blood thinners? No_____ Yes_____

What non-prescription drugs, vitamins or supplements are you taking?

_____

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 inform that doctor's office of any changes in my medical status. I authorize the health staff to perform the necessary services I may need and release information to others if necessary for my care.

Signature of patient Date