REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW.

CONSTITUTIONAL SYMPTOMS

- GOOD GENERAL HEALTH ☐ YES ☐ NO
- RECENT WEIGHT CHANGE ☐ YES ☐ NO
- FEVER ☐ YES ☐ NO
- FATIGUE ☐ YES ☐ NO
- HEADACHES ☐ YES ☐ NO
- WT: GAIN_____LB LOSS_____LB

EYES/EARS/NOSE/MOUTH/THROAT

- EYE DIESEASE OR INJURY ☐ YES ☐ NO
- WEAR GLASSES/CONTACT LENSES ☐ YES ☐ NO
- BLURRED OR DOUBLE VISION ☐ YES ☐ NO
- GLAUCOMA ☐ YES ☐ NO
- HEARING LOSS OR RINGING ☐ YES ☐ NO
- EARACHE OR DRAINAGE ☐ YES ☐ NO
- CHRONIC SINUS PROBLEMS ☐ YES ☐ NO
- NOSE BLEEDS ☐ YES ☐ NO
- MOUTH SORES ☐ YES ☐ NO
- BLEEDING GUMS ☐ YES ☐ NO
- BAD BREATH OR BAD TASTE ☐ YES ☐ NO
- SORE THROAT OR VOICE CHANGE ☐ YES ☐ NO
- SWOLLEN GLANDS IN NECK ☐ YES ☐ NO

CARDIOVASCULAR

- HEART TROUBLE ☐ YES ☐ NO
- CHEST PAIN/ANGINA PECTORIS ☐ YES ☐ NO
- PALPITATIONS ☐ YES ☐ NO
- SHORTNESS OF BREATH WITH WALKING/ LYING FLAT ☐ YES ☐ NO
- SWELLING OF FEET, ANKLES OR HANDS ☐ YES ☐ NO

RESPIRATORY

- CHRONIC OR FREQUENT COUGH ☐ YES ☐ NO
- SPITTING UP BLOOD ☐ YES ☐ NO
- SHORTNESS OF BREATH ☐ YES ☐ NO
- ASTHMA OR WHEEZING ☐ YES ☐ NO

GASTROINTESTINAL

- LOSS OF APPETITE ☐ YES ☐ NO
- CHANGE IN BOWEL MOVEMENTS ☐ YES ☐ NO
- NAUSEA OR VOMITING ☐ YES ☐ NO
- FREQUENT DIARRHEA ☐ YES ☐ NO
- PAINFUL BOWEL MOVEMENTS OR CONSTIPATION ☐ YES ☐ NO
- RECTAL BLEEDING OR BLOOD IN STOOL ☐ YES ☐ NO
- PEPTIC ULCER (STOMACH OR DUODENAL) ☐ YES ☐ NO

GENITOURINARY

- FREQUENT URINATION ☐ YES ☐ NO
- BURNING OR FAINFUL URINATION ☐ YES ☐ NO
- BLOOD IN URINE ☐ YES ☐ NO
- CHANGE IN FORCE OF STREAM WHEN URINATING ☐ YES ☐ NO
- INCONTINENCE OR DRIBBLING ☐ YES ☐ NO
- KIDNEY STONES ☐ YES ☐ NO
- SEXUAL DIFFICULTY ☐ YES ☐ NO

GYNECOLOGICAL

- PAIN WITH PERIODS ☐ YES ☐ NO
- IRREGULAR PERIODS ☐ YES ☐ NO
- VAGINAL DISCHARGE ☐ YES ☐ NO
- HISTORY OF HORMONE/ESTROGEN USE? ☐ YES ☐ NO
- NUMBER OF PREGNANCIES _____
- NUMBER OF MISCARRIAGES _____
- DATE OF LAST MENSTRUAL PERIOD _____

CANCER SCREENING

- DATE OF LAST COLONOSCOPY _____
- DATE OF LAST PSA _____
- DATE OF LAST PAP SMEAR _____
- DATE OF LAST MAMMOGRAM _____

MUSCULOSKELETAL

- JOINT PAIN ☐ YES ☐ NO
- JOINT STIFFNESS OR SWELLING ☐ YES ☐ NO
- WEAKNESS OF MUSCLES OR JOINTS ☐ YES ☐ NO
- MUSCLE PAIN OR CRAMPS ☐ YES ☐ NO
- BACK PAIN ☐ YES ☐ NO
- COLD EXTREMITIES ☐ YES ☐ NO
- DIFFICULTY IN WALKING ☐ YES ☐ NO

SKIN

- RASH OR ITCHING ☐ YES ☐ NO
- CHANGE IN SKIN COLOR ☐ YES ☐ NO
- CHANGE IN HAIR OR NAILS ☐ YES ☐ NO
- VARICOSE VEINS ☐ YES ☐ NO

BREASTS

- BREAST PAIN ☐ YES ☐ NO
- BREAST LUMP ☐ YES ☐ NO
- BREAST DISCHARGE ☐ YES ☐ NO

NEUROLOGICAL

- FREQUENT OR RECURRING HEADACHES ☐ YES ☐ NO
- LIGHT HEADED OR DIZZY ☐ YES ☐ NO
- CONVULSIONS OR SEIZURES ☐ YES ☐ NO
- NUMBNESS OR TINGLING SENSATIONS ☐ YES ☐ NO
- TREMORS ☐ YES ☐ NO
- PARALYSIS ☐ YES ☐ NO
- STROKE ☐ YES ☐ NO
- HEAD INJURY ☐ YES ☐ NO

PSYCHIATRIC

- MEMORY LOSS OR CONFUSION ☐ YES ☐ NO
- NERVOUSNESS ☐ YES ☐ NO
- DPRESSION ☐ YES ☐ NO
- INSOMNIA ☐ YES ☐ NO

ENDOCRINE

- GLANDULAR OR HORMONE PROBLEM ☐ YES ☐ NO
- THYROID DISEASE ☐ YES ☐ NO
- DIABETES (INSULIN OR NON-INSULIN CIRCLE ONE) ☐ YES ☐ NO
- EXCESSIVE THIRST OR URINATION ☐ YES ☐ NO
- HEAT OF COLD INTOLERANCE ☐ YES ☐ NO
- SKIN BECOMING DRYER ☐ YES ☐ NO
- CHANGE IN HAT OR GLOVE SIZE ☐ YES ☐ NO

HEMATOLOGIC/LYMPHATIC

- SLOW TO HEAL AFTER CUTS ☐ YES ☐ NO
- BLEEDING OR BRUISING TENDENCY ☐ YES ☐ NO
- ANEMIA ☐ YES ☐ NO
- PHLEBITIS/BLOOD CLOTS ☐ YES ☐ NO
- PAST TRANSFUSIONS ☐ YES ☐ NO
- ENLARGED GLANDS ☐ YES ☐ NO
- PULMONARY EMBOLUS ☐ YES ☐ NO

TESTS (LIST FINDINGS IF KNOWN IN SPACE BELOW)

- DATE OF LAST CT SCAN _____
- DATE OF LAST BONE SCAN _____
- DATE OF LAST PET SCAN _____
- OTHER SCANS (LIST) _____

NURSE SIGNATURE_____
DATE_____

PHYSICIAN SIGNATURE _____

DATE _____

(PLEASE USE THE BACK FOR PATIENT'S HPI)