REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less then optimal function.

Check either **I DENY having/had** OR **Circle P for PAST** OR **Circle N for NOW**

CONSTITUTIONAL

❒ **I DENY** having or having had any of the **symptoms or problems listed below.**

P N chills
P N daytime drowsiness
P N fatigue
P N fever
P N night sweats
P N weight gain
P N weight loss

EYES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Wear glasses or contact lenses
P N blindness
P N Cataracts
P N Glaucoma

EARS / NOSE / THROAT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Difficulty/Loss of hearing
P N Ringing in the ears (tinnitus)
P N Frequent ear aches
P N Discharge from the ear
P N Attacks of vertigo
P N Sinus trouble
P N Nasal blockage
P N Frequent sneezing
P N Frequent sore throat
P N Snoring
P N Recent change in voice quality
P N Sleep apnea
P N Difficulty in swallowing
P N Nose bleeds

RESPIRATORY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Asthma or wheezing
P N Recent bronchitis or chest cold
P N Cough
P N Coughing up blood
P N Shortness of breath

HEART & CIRCULATION

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Heart attack
P N High blood pressure
P N Heart murmur
P N Chest discomfort (angina)
P N Heart failure or fluid on the lungs
P N Palpitations, racing or pounding
P N Shortness of breath w/activity
P N Stroke / mini stroke or TIA
P N Blood clot in artery or vein
P N "Black out spells"
P N Aneurysm of any blood vessel
P N Swelling of legs
P N Heart surgery
P N Heart palpitations

STOMACH / INTESTINES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Ulcer
P N Frequent heartburn or indigestion
P N Hiatal hernia and or acid reflux
P N Poor appetite
P N Gall bladder attacks
P N Frequent diarrhea
P N Chronic constipation
P N Bright blood bowels or rectum
P N Abnormal stool
P N Liver disease or jaundice

ENDOCRINE / METABOLISM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Thyroid disorder
P N Unusual hair loss or growth
P N goiter
P N Diabetes

KIDNEYS / URINARY TRACT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Kidney disease or failure
P N History of kidney dialysis
P N Kidney stones or infection
P N Pain or burning with urination
P N Trouble starting urinary stream
P N Dribbling or incontinence
P N Frequent Night Urination
P N Bladder infections during past year
P N Blood in urine during past year

MUSCLES / BONES / JOINTS

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Arthritis or other joint disease
P N Chronic back trouble
P N Bone or joint surgery in past year

ALLERGY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N anaphylaxis
P N food intolerance
P N itching
P N nasal congestion
P N rash
P N sneezing

SKIN

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Rashes, psoriasis or dermatitis
P N History of skin cancer
P N New skin growth or mole

NERVOUS SYSTEM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Headache
P N Epilepsy or seizures
P N Date of last seizure:_____
P N Depression
P N Other nervous disorder
Specify:_____

PSYCHOLOGIC

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N anxiety
P N loss or change in appetite
P N behavioral change
P N bi-polar disorder
P N confusion
P N convulsions
P N depression
P N insomnia
P N memory loss
P N mood change

BLOOD

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Bleeding or bruising tendency
P N Previous blood transfusion
P N History of hepatitis

MEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Testicular swelling
P N Prostate Problems
P N Frequent urination

WOMEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Painful periods
P N Excessive Flow
P N Irregular cycles
P N Vaginal Burning
P N Hot Flash

Are you pregnant? Yes No

Past Medical and Family History

Surgical History: (NONE)_____

Hospitalization History: (NONE) _____

Allergy History: (NONE) _____

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): _____

HEIGHT _____ **WEIGHT**_____ **BLOOD PRESSURE** _____ **PULSE**_____ ❑ N/A MINOR

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

Signature: _____ Date: _____

Print Name: _____