

Review of Systems

Patient Name: _____ DOB: _____ MR#: _____

Date: _____ Sex: M / F Chief Complaint: _____

Primary Physician: _____ Referring Physician: _____

GENERAL			CARDIOVASCULAR		
Any weight gain/loss of > 10# last 6 months? Circle one	Yes	No	Do you have irregular heartbeats?	Yes	No
Any change in appetite or interest in eating?	Yes	No	Do you have fast heartbeats?	Yes	No
Have you ever had cancer? Which type?	Yes	No	Do you have shortness of breath that awakens you?	Yes	No
Have you ever had prior radiation treatment?	Yes	No	Do you have chest pain or shortness of breath with exertion?	Yes	No
HEAD/NECK			Have you ever had leaky or bad heart valve?	Yes	No
Do you have headaches > 1 week?	Yes	No	Have you ever had rheumatic fever?	Yes	No
Do you have sinus disease/allergies/hay fever? Circle one	Yes	No	Have you ever had leg pain that begins when you are walking?	Yes	No
Does your nose stop/run when you do not have a cold? Circle one	Yes	No	GASTROINTESTINAL - GI		
Do you have nosebleeds?	Yes	No	Have you had a change in appetite or weight?	Yes	No
Do you have problems with teeth or gums?	Yes	No	Have you had nausea?	Yes	No
Have you had a change in your voice or recent hoarseness?	Yes	No	Have you had a change in size, color, or frequency, or stools? Circle one	Yes	No
EARS			Have you had blood in your bowel movement?	Yes	No
Do you have difficulty hearing?	Yes	No	Have you had jaundice or liver disease?	Yes	No
Do you have buzzing or noise in your ears?	Yes	No	Have you had hepatitis?	Yes	No
Have you ever had ear surgery?	Yes	No	Have you had any difficulty swallowing?	Yes	No
Have you ever had mastoiditis?	Yes	No	Have you had recent diarrhea?	Yes	No
EYES			BLADDER/KIDNEY - GU		
Do you wear glasses or contacts?	Yes	No	Do you get up at night to urinate?	Yes	No
Have you had any recent vision changes?	Yes	No	Have you had kidney disease?	Yes	No
Have you had optic neuritis?	Yes	No	Have you ever had venereal disease?	Yes	No
Do you see double?	Yes	No	Have you ever had kidney stones?	Yes	No
CHEST			Have you ever had prostate problems?	Yes	No
Do you have or have you ever had chest pain?	Yes	No	MUSCULOSKELETAL		
Do you have or have you ever had shortness of breath?	Yes	No	Have you had joint or muscle pain?	Yes	No
Do you have or have you ever had wheezing?	Yes	No	Do you have pain, swelling, or redness in your joints? Circle one	Yes	No
Do you have or have you ever had tuberculosis or positive skin test?	Yes	No	Have you ever had osteoporosis?	Yes	No
Do you have or have you ever had pneumonia?	Yes	No	Have you ever had night cramps?	Yes	No
Do you have or have you ever had asthma or emphysema/COPD? Circle one	Yes	No	Have you ever had sprains or fractures?	Yes	No
Do you have shortness of breath when lying flat?	Yes	No	Are you handicapped in any way?	Yes	No
Do you cough up phlegm on a regular basis?	Yes	No	ENDOCRINE/METABOLIC		
BLOOD DISORDERS			Have you ever had thyroid problems?	Yes	No
Have you ever been anemic?	Yes	No	Have you ever had frequent urination?	Yes	No
Have you ever had sickle cell anemia?	Yes	No	Have you ever had sugar in your urine?	Yes	No
Have you ever had spherocytosis?	Yes	No	Have you ever had diabetes?	Yes	No
Have you ever had unusual bleeding?	Yes	No	Have you ever had high cholesterol?	Yes	No
Have you ever had a personal or family history of clotting?	Yes	No	LYMPH		
			Do you have any enlarged lymph nodes?	Yes	No
			Do you have draining or infected lymph nodes?	Yes	No

SKIN			BREASTS		
Do you have any skin sores or rashes?	Yes	No	Has it been over one year since your last PAP mammogram?	Yes	No
Do you have any itching?	Yes	No		Yes	No
Do you have any bruising or bleeding?	Yes	No	Have you ever had lumps or pain in your breasts?	Yes	No
Do you have any drainage from under your skin?	Yes	No		Yes	No
Do you have any moles that have changes?	Yes	No	Have you ever had any discharge from your breasts?	Yes	No
CENTRAL NERVOUS SYSTEM			Has it been over one month since you did a breast self-examination?	Yes	No
Have you ever had a stroke or "mini-stroke"?	Yes	No		Yes	No
Have you ever had paralysis?	Yes	No	NUTRITION		
Have you ever had unusual muscle movement?	Yes	No	Do you eat as least three meals a day?	Yes	No
Have you ever had spine injury or pain?	Yes	No	If no, how many? _____		
Have you ever had epilepsy or seizures?	Yes	No	Do you have a fruit or vegetable at each meal?	Yes	No
Have you ever had a head injury?	Yes	No	Do you eat protein at each meal?	Yes	No
Have you ever been knocked unconscious?	Yes	No	(meat, beans, nuts, lentils, soy, protien supplement)		
Have you ever had trouble walking?	Yes	No	Do you know how many calories you need to consume in a day?	Yes	No
Have you ever had trembling or shaking?	Yes	No	Would you like a meal plan for wound healing?	Yes	No
Have you ever had hallucinations?	Yes	No			
Have you ever had a nervous breakdown?	Yes	No			
Have you ever had depression?	Yes	No			
Have you ever used illicit drugs of any kind?	Yes	No			
REPRODUCTIVE SYSTEM					
When was your last period?	Yes	No			
Was your last period unusual?	Yes	No			
Do you spot or bleed between periods?	Yes	No			
Have you had a miscarriage or abortion?	Yes	No			
Are you taking birth control pills?	Yes	No			
Do you use birth control?	Yes	No			
Have you ever had complications with birth control?	Yes	No			
Have you ever had an abnormal PAP test?	Yes	No			
Has it been over one year since your last PAP test?	Yes	No			

PAST MEDICAL HISTORY

Medications:

ALLERGIES:

Immunizations:

Surgeries:

Hospitalizations:

Wound Care in the Past:

Do you take or have you taken an of the following medications?

Cisplatin, Carboplatin, or any platinum containing chemotherapy agents?	Yes	No	Disulfiram (Antabuse)	Yes	No
			Acetazolamide (Diamox)	Yes	No
Doxorubicin (Adriamycin)	Yes	No	Novantrone	Yes	No
Bleomycin	Yes	No			

Are you currently pregnant or trying to conceive?	Yes	No
Do you have a pacemaker?	Yes	No

List all your current and previous occupations:

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FAMILY HISTORY

Seizures	Yes	No	Hypertension (HTN)	Yes	No
Coronary Artery Disease (CAD)	Yes	No	Diabetes Mellitus (DM)	Yes	No
Congestive Heart Failure (CHF)	Yes	No	Cancer	Yes	No
Asthma	Yes	No	Negative	Yes	No
COPD	Yes	No	Adopted	Yes	No
Pneumothorax	Yes	No			

SOCIAL HISTORY

Cigarettes? If "yes"...How many packs per day? How many years?	Yes	No	Alcohol? If "yes" How many drinks per day?	Yes	No
Recreational Drugs? If "yes"...Which drugs? How often?	Yes	No	Caffeine? If "yes" How much per day?	Yes	No

Living Conditions

Mobility

Nursing Home	Yes	No	Unassisted	Yes	No
Assisted Living	Yes	No	With assistance	Yes	No
Lives alone	Yes	No	With cane or crutches	Yes	No
Live with family	Yes	No	Walker	Yes	No
			Transfers only	Yes	No
			Wheelchair	Yes	No
			Other	Yes	No

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