Patient Name:_____**Date:**_____
Referring Physician:_____ **DOB:**_____

Review of Systems :

1) *Please check all problems that you have OR Please check "None"*

Constitutional: □*None* □fevers (how high? ____)□chills □loss of appetite □hair loss
□ Unexplained weight (circle) GAIN/LOSS; if yes-when? _____ how much?_____

EYES: □*None* □pain □vision changes □double vision □itching

ENT: □*None* **Ear:** □pain □discharge □lump □hearing loss □tinnitus **(circle one)** left/right/both
Nose: □pain □discharge □lump □loss of smell □stuffy **(circle one)** left/right/both
Mouth: □pain □discharge □lump □loss of taste □cavities □dentures
Throat: □pain □lump □thick mucus □tickle □cough □trouble swallowing □hoarse voice

Cardiovascular: □*None* □chest pain □history of heart attack □shortness of breath □leg cramps
□irregular heart beat □history of heart disease/coronary artery disease

Respiratory: □*None* □cough □sputum □wheezing □asthma □COPD □pneumonia □tuberculosis

GI: □*None* □nausea □diarrhea □constipation □blood in stool □hepatitis □vomiting

Urinary: □*None* □kidney stones □bladder infections □frequent urination □difficult urination
□bloody urine □bladder cancer □painful urination

Neuro: □*None* □history of stroke □headache □weakness □seizures □vision changes
□double vision □cataracts

Musculoskeletal: □*None* □joint pain □joint swelling □muscle pain □swelling □stiffness

Skin: □*None* □birthmark (where?_____) □rash(where?_____)
□lesions (where?_____)

Psychiatric: □*None* □anxiety □depression □mood swings □other_____

Endocrine: □*None* □always cold/hot □hot flashes □irregular periods □frequent sweating

Hematologic: □*None* □easy bruising □history of anemia □lethargy

Allergic/Immuno: □*None* □sneezing □itching □runny nose □frequent colds/infections □history of AIDS

2) *Please sign here:*

The responses above are accurate to the best of my knowledge:_____
(signature)

_____
(date)

If you are not the patient, please print your *name* _____

and *relationship to the patient*:_____

Please do not write below this line

Date updated; _____ **Reviewed by;** (initials) _____ **□BJB □LVC □PBS**