

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Review of Systems: Please indicate any personal history of currently active problems.

**CONSTITUTIONAL SYMPTOMS**

Good general health	YES	NO
Recent Weight Change	YES	NO
Fever/Night Sweats	YES	NO
Excess Fatigue	YES	NO

**EYES**

Eye disease or injury	YES	NO
Glaucoma/cataracts	YES	NO

**EARS/NOSE/THROAT**

Problems with hearing	YES	NO
Sore throat	YES	NO
Voice changes	YES	NO
Swollen glands	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO

**CARDIOVASCULAR**

Heart trouble (murmur, rheumatic fever, valve disease, pacemaker)	YES	NO
Heart attack	YES	NO
Artificial valve	YES	NO
Chest pain/angina	YES	NO
Palpitation	YES	NO
Shortness of breath	YES	NO
Swelling in feet/ankles	YES	NO
Poor circulation	YES	NO
High blood pressure	YES	NO

**RESPIRATORY**

Lung disease	YES	NO
Difficulty breathing	YES	NO
Asthma/wheezing	YES	NO

**GASTROINTESTINAL**

Intestinal/stomach disease	YES	NO
Liver or gallbladder disease	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

**GENITOURINARY**

Bladder Problems	YES	NO
Kidney Problems	YES	NO
Urination problems	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male testicle pain/lumps	YES	NO
Prostate problems	YES	NO
Female irregular periods	YES	NO
Vaginal yeast infection	YES	NO
Estrogen replacement	YES	NO
Hysterectomy	YES	NO
Pregnant or nursing	YES	NO
Planning a pregnancy	YES	NO
Current form of birth control	_____	
Last menstrual period	_____	
Age of onset of menopause	_____	

**MUSCULOSKELETAL**

Joint pain	YES	NO
Joint stiffness	YES	NO
Weakness of muscles	YES	NO
Artificial joints	YES	NO

**INTEGUMENTARY (skin/breasts)**

Problems with scarring/keloids	YES	NO
History of radiation treatment	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

**NEUROLOGIC**

Frequent/recurring headaches	YES	NO
Lightheaded or dizzy	YES	NO
Convulsions/seizures	YES	NO
Stroke	YES	NO

**PSYCHIATRIC**

Nervousness	YES	NO
Depression	YES	NO
Other	YES	NO

**ENDOCRINE**

Glandular of hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes (insulin or no insulin)	YES	NO

**HEMATOLOGIC/LYMPHATIC**

Taking blood thinners now	YES	NO
Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Blood or lymph gland disorder	YES	NO
Cancer or leukemia	YES	NO

**ALLERGY/IMMUNOLOGY INFECTIOUS**

<b>DISEASE</b>		
History of venereal disease (STD)	YES	NO
History of HIV infection (AIDS)	YES	NO
History of hepatitis	YES	NO
History of frequent infections	YES	NO
If yes, where? _____		
History of reaction to:		
Local anesthesia	YES	NO
Latex/rubber	YES	NO

**Food allergies:** \_\_\_\_\_

**Environmental allergies:** \_\_\_\_\_

Any other health problems: \_\_\_\_\_