

Patient Name: _____ Date of Birth: _____

Review of Systems: **Please indicate any personal history below:**

Constitutional / General

Fever..... Yes No
 Weight Loss..... Yes No
 Night Sweats..... Yes No
 Excessive Fatigue..... Yes No

Eyes

Wear Glasses..... Yes No
 Infections..... Yes No
 Injuries..... Yes No
 *Glaucoma..... Yes No
 *Cataracts..... Yes No
 If yes, operated? (right/left) Yes No
 *Macular Degeneration..... Yes No
 Itchy/watery eyes..... Yes No

Ear

Wear Hearing Aids..... Yes No
 Hearing Loss..... Yes No
 If yes, circle one of the following:
Left / Right / Both Sides
 Ear Pain..... Yes No
 Ringing in the Ears..... Yes No
 If yes, circle all that apply:
Left / Right / Both Sides
Rarely / Occasional / Constant
 Dizziness..... Yes No
 If yes, circle all that apply:
Spinning Vertigo / Lightheadedness / Imbalance
 Exposure to Loud Noise..... Yes No
 If yes, list: _____

Nose, Throat, and Mouth

Nose Bleeds..... Yes No
 Nasal Congestion..... Yes No
 Inability to Smell..... Yes No
 Sinus Problems..... Yes No
 Sinus Headaches..... Yes No
 Sore Throat..... Yes No
 Hoarseness..... Yes No
 Difficulties Swallowing..... Yes No
 Speech Delay/Difficulties..... Yes No
 Pain Swallowing..... Yes No

Respiratory

Chronic Cough..... Yes No
 *Emphysema..... Yes No
 Shortness of Breath..... Yes No
 *Bronchitis..... Yes No
 *Pneumonia..... Yes No
 Lung Cancer..... Yes No
 Blood Sputum..... Yes No

Cardiovascular

Chest Pain or Angina..... Yes No
 Irregular Pulse..... Yes No
 *Heart Murmur..... Yes No
 Swelling in Feet or Hands..... Yes No
 Leg Pain While Walking..... Yes No

Musculoskeletal

Broken Bones..... Yes No
 Arm or Leg Weakness..... Yes No
 Back Pain..... Yes No
 Arm or Leg Pain..... Yes No
 Joint Pain or Swelling..... Yes No

Integumentary

Skin Disease..... Yes No
 Skin Cancer..... Yes No

Gastrointestinal

Indigestion/Pain with Eating... Yes No
 Nausea..... Yes No
 Vomiting..... Yes No
 *Liver Disease..... Yes No
 Jaundice..... Yes No
 Abnormal Pain..... Yes No
 *Ulcers or Gastritis..... Yes No
 Colon Cancer..... Yes No
 Heartburn..... Yes No
 Reflux..... Yes No

Genitourinary

Urinary Tract Infections..... Yes No
 Blood in Your Urine..... Yes No
 Incontinence..... Yes No
 Prostate Cancer (males)..... Yes No
 *Endometriosis (females).... Yes No
 Uterine/Cervical Cancer..... Yes No

Hematologic/Lymphatic

*Anemia..... Yes No
 *Hemophilia..... Yes No
 Persistent Swollen Glands.... Yes No
 Swollen Lymph Nodes..... Yes No
 Blood Transfusion..... Yes No
 If yes, when? _____

Psychiatric

*Anxiety..... Yes No
 *Depression..... Yes No
 *Bipolar Disorder..... Yes No
 Other Psychiatric Disorder.. Yes No
 If yes, please list: _____

Endocrine

Increased Appetite..... Yes No
 Excessive Thirst/Urination... Yes No
 Hormone Problems..... Yes No

Allergic/Immunologic

*Immunological Disorders.. Yes No
 Food Allergies..... Yes No
 *Inhalant (Nasal) Allergies.. Yes No
 *Previously allergy tested.... Yes No

Neurological

Fainting Spells/Black Outs... Yes No
 *Seizures..... Yes No
 Problems with Memory..... Yes No
 Disorientation..... Yes No
 Difficulty with Your Speech... Yes No
 Inability to Concentrate..... Yes No
 Double or Blurred Vision..... Yes No
 Face Weakness..... Yes No
 Poor Coordination in
 Arms and/or Legs..... Yes No
 Weakness in Arms or Legs... Yes No
 Numbness, tingling or
 increased sensitivity in your
 feet? Yes No
 Pain, burning or feelings
 of pins/needles in your feet. Yes No
 *Neuropathy Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be detrimental to my health. It is my responsibility to inform this office of any changes in my medical status/condition. I hereby authorize the healthcare staff to perform any necessary services I may require.

Signature of Patient, Parent or Guardian _____

Date _____