

# Review of Systems

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Where do you currently reside? (Circle one) Independently In an Assisted Living Facility In a Nursing Home

## Gastrointestinal

Nausea No Yes  
Vomiting No Yes  
Heartburn No Yes  
Food sticking in throat No Yes  
Painful swallowing No Yes  
Vomiting blood No Yes  
Black stool No Yes  
Red blood in stool No Yes  
Abdominal pain No Yes  
Constipation No Yes  
Diarrhea No Yes  
Loss of appetite No Yes  
Early satiety No Yes  
(feeling full fast)  
Bloating No Yes

## HEENT

Sore throat No Yes  
Hoarseness No Yes

## Cardiovascular

Abnormal heart rhythm No Yes  
Chest pain No Yes  
Palpitations No Yes

## Respiratory

Cough No Yes  
Shortness of breath on exertion No Yes  
Shortness of breath at rest No Yes  
Wheezing No Yes

## Neurological

Seizures No Yes  
Headaches No Yes

## Dermatology

Rash No Yes

## Musculoskeletal

Joint pain No Yes  
Arthritis No Yes

## Psychiatric

Dementia No Yes  
Depression No Yes  
Anxiety No Yes

## Constitutional

Recent weight gain No Yes  
# of pounds \_\_\_\_\_  
Recent weight loss No Yes  
# of pounds \_\_\_\_\_  
Fever No Yes  
Fatigue No Yes

## Genitourinary

Frequent urination No Yes  
Kidney failure/dialysis No Yes  
Painful urination No Yes  
Date of last menstrual period \_\_\_\_\_

Are you taking any blood thinners (Coumadin, Warfarin, Plavix, Pletal, Pradaxa, etc.) NO\_\_ YES\_\_

Current Medication-Please list all prescription and over the counter medicines including doses


## Medical History

Ascites (extra fluid in abdomen)	No Yes	High Blood Pressure	No Yes
Asthma	No Yes	Kidney Failure	No Yes
Bleeding Disorder	No Yes	Kidney Stones	No Yes
Cancer What type _____	No Yes	Liver Disease	No Yes
Congestive Heart Failure (CHF)	No Yes	Migraine Headaches	No Yes
Coronary Artery Disease (CAD)	No Yes	Pancreatitis	No Yes
Depression	No Yes	Peripheral Vascular Disease	No Yes
Diabetes	No Yes	Rheumatic Fever	No Yes
Emphysema or COPD	No Yes	Seizures	No Yes
Endometriosis	No Yes	Sleep Apnea	No Yes
Gallstones	No Yes	Stomach Ulcer	No Yes
Heart Arrhythmia (A. Fib/ SVT/ A.Flutter)	No Yes	Stroke/TIA	No Yes
Heart Attack	No Yes	Thyroid Disease	No Yes
Hepatitis	No Yes	Valvular Heart disease or Endocarditis	No Yes

\_\_\_\_\_ reviewed w/ patient

04/24/2014

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Drug Allergies/Intolerance**


**Past Surgical History**

<b>Abdominal Surgery</b>	No Yes	<b>Gallbladder Removal</b>	No Yes
What type _____		<b>Heart Valve Replacement</b>	No Yes
<b>Appendectomy</b>	No Yes	<b>Hemorrhoid Removal</b>	No Yes
<b>Cancer Surgery</b>	No Yes	<b>Hip, Shoulder, Knee replacement</b>	No Yes
What type _____		<b>within 1 year</b>	
<b>Coronary Artery Bypass (CABG)</b>	No Yes	<b>Hysterectomy (TAH)</b>	No Yes
<b>Coronary Stent</b>	No Yes	<b>Laparoscopy</b>	No Yes
<b>Cosmetic Surgery</b>	No Yes	<b>Pacemaker</b>	No Yes
What type _____		<b>Salpingoophorectomy (BSO)</b>	No Yes
<b>Defibrillator</b>	No Yes	<b>(tube and ovary removal)</b>	
If yes, we need a copy of the card		<b>Tonsillectomy</b>	No Yes
		<b>Vascular Bypass/grafts within 1 yr</b>	No Yes

**Hospitalizations (non-surgical)**

\_\_\_\_\_

\_\_\_\_\_

**Family Medical History (not you) If Yes, please list the relative and age**

Colon Cancer	No Yes	_____
Colon Polyps	No Yes	_____
Inflammatory Bowel Disease (IBD)	No Yes	_____
 Cancer of:		
Endometrial	No Yes	_____
Esophagus	No Yes	_____
Kidney	No Yes	_____
Ovarian	No Yes	_____
Pancreas	No Yes	_____
Small Bowel	No Yes	_____
Stomach	No Yes	_____

**Social History**

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Children: No \_\_\_\_\_ Yes \_\_\_\_\_ How many? \_\_\_\_\_

Use of Alcohol: None \_\_\_\_\_ Yes \_\_\_\_\_ How much? \_\_\_\_\_

Use of Tobacco: Never \_\_\_\_\_ Quit \_\_\_\_\_ Yes \_\_\_\_\_ How much? \_\_\_\_\_

Employer and Occupation: \_\_\_\_\_

**Authorization & Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Signature of patient

Date