*Do not write, stamp, punch holes or affix a sticker in this area.*

# Review of Systems

Please answer every question

*To reproduce, follow the printing instructions. Do not fold this form.*

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

**First Visit:** **Mark all symptoms that pertain to you.**
**Repeat Visit:** **Mark only the symptoms that you have experienced since your last visit.**

***Mark all that apply. If no symptoms, please mark "NONE".***

### GENERAL

- fevers
- appetite loss
- chills
- weight gain
- weight loss
- excessive perspiration
- "feeling sick"
- NONE

### EYES

- vision loss – 1 eye
- vision loss – both eyes
- "halos" around lights
- double vision
- blurring
- discharge
- eye irritation
- eye pain
- light sensitivity
- NONE

### EARS / NOSE / THROAT

- ringing in the ears
- decreased hearing
- difficulty swallowing
- ear discharge
- nasal congestion
- hoarseness
- earache
- nosebleeds
- sore throat
- NONE

### CARDIOVASCULAR

- difficulty breathing at night
- racing / skipping heartbeats
- shortness of breath with exertion
- difficulty breathing while lying down
- bluish discoloration of lips
- near fainting
- fainting
- palpitations
- fatigue
- chest pain or discomfort
- lightheadedness
- swelling of hands
- swelling of ankles
- leg cramps with exertion
- NONE

### RESPIRATORY

- sleep disturbances due to breathing
- coughing up blood
- excessive sputum
- cough
- chest discomfort
- excessive snoring
- shortness of breath
- wheezing
- NONE

### GASTROINTESTINAL

- excessive appetite
- vomiting blood
- yellowish skin color
- abdominal bloating
- change in bowel habits
- bloody stools
- loss of appetite
- nausea
- gas
- hemorrhoids
- constipation
- indigestion
- vomiting
- abdominal pain
- diarrhea
- dark tarry stools
- NONE

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# Review of Systems

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## GENITOURINARY

- nighttime urination
- blood in urine
- lack of sexual drive
- urinary frequency
- trouble starting urinary stream
- inability to control bladder
- excessively heavy periods
- other abnormal vaginal bleeding
- NONE

## MUSCULOSKELETAL

- joint swelling
- stiffness
- gout
- joint pain
- back pain
- muscle aches
- muscle cramps
- arthritis
- muscle weakness
- loss of strength
- NONE

## SKIN

- poor wound healing
- itching
- rash
- night sweats
- dryness
- flushing
- skin cancer
- suspicious lesions
- unusual hair distribution
- changes in color of skin
- NONE

## NEUROLOGIC

- headaches
- sudden inability to speak
- brief paralysis of limbs
- weakness of limbs
- tingling
- poor balance
- numbness
- tremors
- memory loss
- difficulty with concentration
- disturbances in coordination
- falling down
- seizures
- sensation of room spinning
- NONE

## PSYCHIATRIC

- depression
- thoughts of suicide
- thoughts of violence
- anxiety
- sense of great danger
- excessive daytime sleeping
- frightening visions or sounds
- NONE

## ENDOCRINE

- cold intolerance
- heat intolerance
- excessive thirst
- excessive hunger or disordered eating
- NONE

## HEMATOLOGIC / LYMPHATIC

- skin discoloration
- bleeding
- enlarged lymph nodes
- abnormal bruising
- NONE

## ALLERGIC / IMMUNOLOGIC

- seasonal allergies
- hives or rash
- persistent infections
- HIV
- NONE

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# Patient History

Please answer every question

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PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## CARDIAC

### CARDIAC HISTORY

**Please indicate if you have had any of the following. Mark all that apply.**

- ◯ abnormal EKG
- ◯ abnormal heart rhythm
- ◯ atrial fibrillation
- ◯ atrial flutter
- ◯ cardiac arrest
- ◯ angina or heart pain
- ◯ heart attack
- ◯ heart artery disease
- ◯ stroke or transient stroke
- ◯ heart valve disease
- ◯ heart murmur
- ◯ high cholesterol
- ◯ high triglycerides
- ◯ leg circulation problems
- ◯ leg clots or phlebitis
- ◯ aneurysm of the aorta
- ◯ congenital heart defect
- ◯ high blood pressure
- ◯ congestive heart failure

### CARDIAC PROCEDURES AND SURGERY

**Please indicate if you have had any of the following. Mark all that apply.**

- ◯ CABG / coronary bypass
- ◯ coronary angioplasty / stent
- ◯ heart valve surgery
- ◯ carotid artery surgery
- ◯ carotid artery stent
- ◯ peripheral artery surgery
- ◯ peripheral artery stent
- ◯ aneurysm repair
- ◯ heart catheterization
- ◯ pacemaker / defibrillator implant
- ◯ ablation of arrhythmia
- ◯ loop recorder insertion
- ◯ IVC filter placement

## PAST GENERAL MEDICAL HISTORY

**Please indicate if you have had any of the following. Mark all that apply.**

- ◯ acid reflux / heartburn
- ◯ AIDS or HIV positive
- ◯ anemia
- ◯ anxiety
- ◯ arthritis
- ◯ asthma
- ◯ blood disorder
- ◯ cancer (any)
- ◯ cataracts
- ◯ chronic lung disease (COPD)
- ◯ convulsions (seizures)
- ◯ depression
- ◯ diabetes (insulin dependent)
- ◯ diabetes (medication, no insulin)
- ◯ gallstones
- ◯ gastrointestinal disease
- ◯ glaucoma
- ◯ gout
- ◯ headaches
- ◯ hepatitis
- ◯ kidney disease
- ◯ kidney stones
- ◯ liver disease
- ◯ prostate
- ◯ rheumatic fever
- ◯ sleep apnea
- ◯ TB or positive skin test
- ◯ thyroid disease
- ◯ ulcers
- ◯ **OTHER MEDICAL ILLNESS NOT LISTED**
- ◯ **NONE**

## PAST GENERAL SURGICAL HISTORY

**Please indicate if you have had any of the following. Mark all that apply.**

- ◯ cancer surgery
- ◯ breast surgery
- ◯ gallbladder removed
- ◯ hiatal hernia repair
- ◯ gastric bypass
- ◯ hysterectomy
- ◯ plastic surgery
- ◯ prostate surgery
- ◯ appendectomy
- ◯ hip replacement
- ◯ knee replacement
- ◯ lap band
- ◯ spine surgery (neck or back)
- ◯ **OTHER SURGERY NOT LISTED**

## FAMILY MEDICAL HISTORY

**Please indicate if YOUR FAMILY has a history of the following.**

○ **Family History UNKNOWN**

**Please indicate which family members have had these illnesses.**

| | Father | Mother | Brother | Sister | Other Relative |
|---|---|---|---|---|---|
| heart artery disease | ○ | ○ | ○ | ○ | ○ |
| heart attack | ○ | ○ | ○ | ○ | ○ |
| heart bypass surgery | ○ | ○ | ○ | ○ | ○ |
| heart stent | ○ | ○ | ○ | ○ | ○ |
| high blood pressure | ○ | ○ | ○ | ○ | ○ |
| congenital heart disease | ○ | ○ | ○ | ○ | ○ |
| congestive heart failure | ○ | ○ | ○ | ○ | ○ |
| sudden cardiac death | ○ | ○ | ○ | ○ | ○ |
| heart rhythm problems | ○ | ○ | ○ | ○ | ○ |
| pacemaker | ○ | ○ | ○ | ○ | ○ |
| defibrillator | ○ | ○ | ○ | ○ | ○ |
| peripheral artery disease | ○ | ○ | ○ | ○ | ○ |
| high cholesterol | ○ | ○ | ○ | ○ | ○ |
| cancer | ○ | ○ | ○ | ○ | ○ |
| diabetes | ○ | ○ | ○ | ○ | ○ |
| stroke | ○ | ○ | ○ | ○ | ○ |

## SOCIAL HISTORY

### TOBACCO USE

**Smoking status:** ○ never ○ current (some days) ○ previous ○ current (every day)

**Have you been advised / counseled to quit?** ○ yes ○ no

**Average number of packs (now or in the past):**

○ None ○ 1 / week ○ 2 / week ○ ¼ / day ○ ½ / day ○ 1 / day ○ 1 ½ / day ○ 2 / day ○ >3 / day

**Number of years you have smoked** *(if intermittent, add up total years):*

○ <1 ○ 1-4 ○ 5 ○ 10 ○ 15 ○ 20 ○ 25 ○ 30 ○ >30

**Average number of cigars per week:** ○ none ○ 2 ○ 5 ○ 10 ○ >10

**Cans of chewing tobacco per week:** ○ none ○ <1 ○ 1 ○ 2 ○ >2

**Second hand smoke?** ○ none ○ minimal ○ moderate ○ considerable

### ALCOHOL USE

**How often?** ○ none ○ <1 / week ○ 1-6 times / week ○ daily

**Number of drinks per occasion:** ○ 1 ○ 2 ○ 3-5 ○ 6-10 ○ >10

**Type(s) of alcohol:** ○ wine ○ beer ○ liquor

### CAFFEINE INTAKE

**Type(s):** ○ none ○ coffee ○ tea ○ soft drinks ○ energy drinks

**Average number per day:** ○ rare ○ <1 ○ 1 ○ 2-3 ○ >3

### DRUG USE

○ none ○ previous ○ current

### EXERCISE

**Average times per week:** ○ none ○ occasional ○ 1-2 ○ 3-5 ○ daily

**Type(s) of exercise:** ○ walking ○ bicycling ○ skiing ○ jog / run ○ aerobics ○ swimming