

HISTORY AND REVIEW OF SYSTEMS

PATIENT NAME: _____

AGE: _____ ACCT. NO. _____

REFERRING PHYSICIAN: _____

DATE OF BIRTH: _____

CHIEF COMPLAINT (What brought you here?): _____

PRESENT ILLNESS: _____

REVIEW OF SYSTEMS:

Have you had any of these problems? Please check Yes or No
Briefly explain Yes answers in space provided

GENERAL SYMPTOMS:		
Fever/Chills	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
EYES:		
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
RESPIRATORY:		
Asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea (using CPAP)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
CARDIOVASCULAR:		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
GASTROINTESTINAL:		
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion/reflux	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
MUSCULOSKELETAL:		
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

GENITOURINARY:		
Bloody urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequency Day	<input type="checkbox"/>	<input type="checkbox"/>
Night	<input type="checkbox"/>	<input type="checkbox"/>
Slow stream	<input type="checkbox"/>	<input type="checkbox"/>
Straining to void	<input type="checkbox"/>	<input type="checkbox"/>
_____ (#)		
Urinary leakage	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Erection problems (men)	<input type="checkbox"/>	<input type="checkbox"/>
MENSTRUAL (women):		
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>
_____ (#)		
Other: _____		
ENDOCRINE/HEMATOLOGICAL:		
Steroid use	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood clotting problems	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
NEUROLOGICAL/PSYCHIATRIC:		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Stress	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

SOCIAL:	Yes	No	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Street Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occupation	_____		
Marital Status	_____		

FAMILY HISTORY	Y	N	WHO?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer (male)	<input type="checkbox"/>	<input type="checkbox"/>	_____

UPDATED: (staff use only)

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