Review of Systems

Patient Name: _____Date of Birth: _____

Why are we seeing you? _____
_____
_____

Medications you are taking (all prescription, over the counter medications, vitamins & herbals)
Name Dose (mg,mcg,ml,etc) Frequency (daily, twice daily, etc)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been told by a doctor that you have…? (Circle Answer)

Renal History

Yes	No	Kidney disease	_____
Yes	No	Kidney stones	_____
Yes	No	High blood pressure	_____
Yes	No	Urine infections	_____
Yes	No	Blood in your urine	_____
Yes	No	Protein in your urine	_____
Yes	No	Foamy urine	_____
Yes	No	Burning with urination	_____
Yes	No	Trouble passing urine	_____
Yes	No	Get up at night to pass urine	How many times? _____
Yes	No	Swelling of legs	_____
Yes	No	Do you check BP	_____

Past Medical History

Yes	No	Diabetes	_____
Yes	No	High blood pressure	_____
Yes	No	Stroke	_____
Yes	No	Seizure disorder	_____
Yes	No	Heart disease	_____
Yes	No	Heart murmur	_____
Yes	No	Heart rhythm disturbance	_____
Yes	No	Emphysema/COPD	_____
Yes	No	Asthma	_____
Yes	No	Blood clots legs or lung	_____
Yes	No	Sleep Apnea	_____
Yes	No	Gastrointestinal bleeding	_____
Yes	No	Liver disease or hepatitis	_____
Yes	No	Thyroid trouble	_____
Yes	No	Cancer	_____
Yes	No	Have you ever had a Blood transfusion?	_____
Yes	No	HIV infection	_____
Yes	No	Tuberculosis	_____
Yes	No	Lupus	_____

For Women

Yes	No	Do you have menstrual periods?
Yes	No	Have you been pregnant? If yes, # of pregnancies?
Yes	No	Did you have toxemia/preeclampsia/complications in any of your pregnancies?
Yes	No	Do you have an annual Pap smear? If yes, any abnormalities?
Yes	No	Do you have a regular mammogram? If yes, any abnormalities?

Other medical history (please specify)

Are you allergic to any medication?

List allergies and state what kind of reaction, if known. Circle "none" if you have no known allergies.

_____
_____
_____
_____

What surgeries (e.g. heart bypass) or interventions (e.g. heart cath or stent) have you had? Please include dates (year is adequate)

Have you been hospitalized recently?

_____

_____

_____

Family Medical History

Member	A – alive D - deceased	Kidney Disease	High blood pressure	Diabetes	Coronary Heart disease	Stroke	Cancer	Autoimmune disease (lupus, RA)
Father								
Mother								
Sibling(s)								
Son(s)								
Daughter(s)								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Paternal Uncle								
Paternal Aunt								
Maternal Uncle								
Maternal Aunt								

Other _____

Social History

Yes No Did you receive the seasonal flu shot this year?
Yes No Do you smoke? If yes, how many packs/day?_____
Yes No Did you previously smoke? If yes, when did you quit?_____
Yes No Do you drink alcohol?If yes, how much?_____
Yes No Do you follow any diet? (low salt, vegetarian, low carb, etc?)_____
_____
What kind of work do you do?_____
If retired, what did you do?_____
What type of exercise do you do, and how often?
_____

Who do you live with? (Circle all that apply)
Spouse Child/children #___ Significant Other Parent(s) Other

Yes No Are you widowed or divorced?

Do you have symptoms such as: (Circle all that apply)

Fever	Loss of appetite
Chills	Weight loss of more than 10lbs
Fatigue or loss of energy	Headaches

Remarks:

Eyes (Circle all that apply)

Blurred vision	Loss of vision
Double vision	Eye pain
Laser therapy	Cataract surgery

Remarks:

Ear/Nose Throat/Mouth (Circle all that apply)

Sinus problems	Sores in mouth
Sore throat	Nose bleeds

Remarks:

Cardiovascular (Circle all that apply)

Chest pain or discomfort	Swelling of legs
Calf pain when walking	

Remarks:

Respiratory (Circle all that apply)

Shortness of breath at rest	Frequent cough
Shortness of breath with walking	Wheezing
Shortness of breath when you lie down	

Remarks:

Gastrointestinal (Circle all that apply)

Abdominal (stomach) pain	Frequent diarrhea
Frequent nausea/vomiting	Frequent heartburn/indigestion

Remarks:

Musculoskeletal (Circle all that apply)

Joint pains	Frequent Muscle pain
Swollen joints	Broken bones

Remarks:

Skin (Circle all that apply)
Skin Rash Persistent itching
Remarks:_____
_____

Neurological (Circle all that apply)
Trouble with memory Pain in your hands or feet
Numbness or tingling in hands or feet
Remarks:_____
_____

Endocrine (Circle all that apply)
Too hot/cold Tired/Sluggish Excessive thirst
Remarks:_____
_____

Hematologic/Lymphatic (Circle all that apply)
Swollen glands Blood clotting problems
Remarks:_____
_____

Immunologic (Circle all immunizations that you have received)
Influenza vaccine Hepatitis B vaccine Pneumococcal vaccine
_____

Psychologic
Yes No In the past month, have you had little interest or pleasure in doing things?
Yes No In the past month, have you felt down, depressed, or hopeless?
Remarks:_____
_____