

Review of System

Please place a check opposite any symptoms you have had:

Constitutional

- Fevers, chills, sweats
- Weight Loss, Changes in Appetite
- Pain that awakens you from sleep
- Excessive Fatigue

Eyes, Ears, Nose, Throat

- Recent changes in vision
- Glaucoma
- Any history of metal fragments in your eyes
- Nose bleeds
- Hearing loss
- Poor Balance

Cardiovascular

- Date/Location of Last EKG: _____
- Chest Pain or Angina
- High Blood Pressure
- Heart Murmur
- Irregular Pulse
- Elevated Cholesterol
- Calf Pain when walking

Respiratory

- Date/ location of last Chest X- ray: _____
- Asthma, Wheezing
- Emphysema
- Chronic Cough
- Pneumonia or Bronchitis
- Blood in sputum
- Lung Cancer

Gastrointestinal

- Ulcer or Gastritis
- Upset Stomach from medicines
Which? _____
- Jaundice or Liver Problems
- Gall Bladder Problems
- Blood in a Stool Specimen
- Colon Cancer

Genitourinary

- Bladder Infection
- Blood in Urine Specimen
- Difficulty with Urination
- Kidney Stones
- Prostate Problems (Males)
- Abnormal Pap Smear/Cancer (Females)

Musculoskeletal

- Swelling in Multiple Joints
- Excessive Flexibility of Joints
- Broken Bones: Which? _____
- Dislocated Joints: Which? _____
- Fibromyalgia
- Reflex Sympathetic Dystrophy

Skin

- Chronic Rashes
- Eczema or Psoriasis
- Skin Cancer or Melanoma
- Breast Lump or Nipple Discharge

Neurological

- Seizures
- Leg Pain or Sciatica
- Weakness or loss of Sensation in Arms or
Legs
- Loss of bowel or Bladder Control
- Stroke When? _____
- Loss of Memory

Psychiatric

- Anxiety
- Depression
- Claustrophobia (fear of confined spaces)
- Other Psychiatric Problem: _____

Endocrine

- Diabetes
- Thyroid problems
- Taken Hormone Replacement
Medication
- Taken Prednisone

Hematologic/ Immunologic

- Anemia
- Easy Bleeding or Bruising
- Blood Transfusion When? _____
- Decreased Resistance to Infection

The Above information is to the best of
my knowledge

Patient signature

Date

I have reviewed this information with
the patient

Physician Signature

Date