

## REVIEW OF SYSTEMS

Today's Date \_\_\_\_\_ Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Have you experienced any of these symptoms lately?

### CONSTITUTIONAL

- Good health lately  YES  NO
- Recent weight loss  YES  NO
- Fever  YES  NO
- Fatigue  YES  NO

### EYE

- Eye diseases  YES  NO
- Blurred vision  YES  NO
- Glaucoma  YES  NO

### EAR/NOSE/MOUTH/THROAT

- Hearing loss  YES  NO
- Ringing in the ears  YES  NO
- Mouth sores  YES  NO
- Bad taste  YES  NO
- Sore tongue  YES  NO
- Sore throat  YES  NO

### CARDIOVASCULAR

- Chest pain  YES  NO
- Shortness of breath  YES  NO
- Swelling of ankles  YES  NO

### RESPIRATORY

- Chronic cough  YES  NO
- Spitting up blood  YES  NO
- Wheezing  YES  NO

### GASTROINTESTINAL

- Poor appetite  YES  NO
- Difficulty swallowing  YES  NO
- Heartburn  YES  NO
- Nausea  YES  NO
- Vomiting  YES  NO
- Bloating  YES  NO
- Belching  YES  NO
- Regurgitation  YES  NO
- Constipation  YES  NO
- Diarrhea  YES  NO
- Abdominal pain  YES  NO
- Rectal pain  YES  NO
- Rectal bleeding  YES  NO

### GENITOURINARY

- Burning with urination  YES  NO
- Blood in the urine  YES  NO
- Incontinence of urine  YES  NO
- Irregular periods  YES  NO
- Number of pregnancies \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_

### MUSCULOSKELETAL

- Joint pain/swelling  YES  NO
- Back pain  YES  NO
- Muscle pain  YES  NO

### SKIN

- Rash  YES  NO
- Itching  YES  NO

### NEUROLOGICAL

- Headaches  YES  NO
- Seizures  YES  NO
- Strokes  YES  NO
- Numbness  YES  NO
- Weakness  YES  NO

### PSYCHIATRIC

- Memory loss/confusion  YES  NO
- Insomnia  YES  NO
- Depression  YES  NO
- Nervousness  YES  NO

### ENDOCRINE

- Heat/cold intolerance  YES  NO
- Excessive thirst  YES  NO
- Excessive urination  YES  NO

### HEMATOLOGICAL

- Bleeding/bruising  YES  NO
- Anemia  YES  NO
- Phlebitis  YES  NO
- Enlarged glands  YES  NO
- Past blood transfusions  YES  NO
- Have you ever been rejected for blood donation?  YES  NO
- Have you ever been given plasma?  YES  NO

Additional comments on any of the above systems

\_\_\_\_\_

FOR STAFF ONLY:

Date form reviewed \_\_\_\_\_

Initials of reviewer \_\_\_\_\_



### PATIENT HISTORY FORM

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation: \_\_\_\_\_

Social History:  Single  Married  Divorced/Separated  Widowed  Partner

**Do You have any allergies to medications, foods, latex or dye?**

\_\_\_\_\_

**Past medical history.** Please list any medical conditions for which you have seen a doctor. (For example: anemia, arthritis, asthma, cancer, diabetes, emphysema, heart disease, heart murmur, hepatitis, high blood pressure, jaundice, kidney disease, stroke etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past surgical history.** Please list any surgeries you have had. (For example: hysterectomy, gallbladder, C-section, heart bypass, hernia repair, lung surgery.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  YES  NO Number of years you have smoked \_\_\_\_\_  
If recently quit - how many years did you smoke? \_\_\_\_\_  
Do you use alcohol?  YES  NO Number of drinks per week? \_\_\_\_\_  
Do you drink coffee/tea/caffeinated soft drinks?  YES  NO

**Family History: Do you have any family member who has or had any of the following:**

- Colorectal Cancer:  Yes  No Who? \_\_\_\_\_
- Other Cancer:  Yes  No Who? \_\_\_\_\_ Type of Cancer: \_\_\_\_\_
- Polyps:  Yes  No Who? \_\_\_\_\_
- Ulcer:  Yes  No Who? \_\_\_\_\_
- Liver Disease:  Yes  No Who? \_\_\_\_\_
- Pancreatitis:  Yes  No Who? \_\_\_\_\_
- Gallbladder Disease:  Yes  No Who? \_\_\_\_\_
- Crohn's Disease:  Yes  No Who? \_\_\_\_\_
- Ulcerative Colitis:  Yes  No Who? \_\_\_\_\_