Patient Name: ________________________________

REVIEW OF SYSTEMS: Please ✓ any of the items that apply to you or that you may be experiencing.

CHIEF COMPLAINT: Please explain in your own words, the reason you are here today.

____

GENERAL HISTORY
Normal Weight:______________
❑ Recent Weight Loss
Amount:__________________
❑ Recent Weight Gain
Amount:__________________
❑ Loss of appetite
❑ Fatigue
❑ Weakness
❑ Fevers
❑ Chills
❑ Night sweats
❑ Sleep problems

EYES
❑ Glasses
❑ Contact Lenses
❑ Glaucoma
❑ Cataracts
❑ Double vision
❑ Change in vision
❑ Other vision problems

EARS/NOSE/THROAT
❑ Loss of hearing
❑ Hearing aid
❑ Ringing in ears
❑ Other ear problems
❑ Dentures
❑ Dental problems
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty swallowing
❑ Dry mouth
❑ Loss of taste
❑ Neck stiffness
❑ Neck pain or swelling

CARDIOVASCULAR
❑ Pacemaker
❑ Chest pain
❑ Irregular heartbeat
❑ Palpitations
❑ Hypertension
❑ Sleep sitting or propped up
❑ Short breath when lying down
❑ Fainting spells
❑ Leg pain while walking
❑ Swelling in feet
❑ Varicose veins
❑ Oxygen use at home

RESPIRATORY
❑ Shortness of breath
❑ Difficulty breathing
❑ Coughing
❑ Dry cough
❑ Coughing up sputum
❑ Coughing up blood

GASTROINTESTINAL
❑ Heartburn
❑ Nausea/upset stomach
❑ Abdominal pain
❑ Vomiting
❑ Jaundice
❑ Change in bowel habits
How long? __________
❑ Constipation
❑ Diarrhea
❑ Blood in stool
❑ Hemorrhoids/fissures

GENITOURINARY
❑ Difficulty urinating
❑ Frequent urination
❑ Painful urination
❑ Up at night to pass urine
❑ Blood in urine
❑ Color change of urine

WOMEN ONLY
Age of Menarche ___ Age of Menopause___
Date of last menstrual period: _______
Date of last pelvic exam: ________
Date of last pap: ________
❑ Hot flashes
❑ Hormone therapy
❑ Currently sexually active
Is there a chance you may be pregnant?
❑ Yes ❑ No
____# of pregnancies ____# living

MEN ONLY
❑ Impotence
❑ Difficulty with erections
❑ Penile discharge
❑ Testicular mass
❑ Testicular pain

MUSCULOSKELETAL
❑ Leg cramps
❑ Painful muscles
❑ Painful joints
❑ Artificial joints
❑ Physical disabilities
❑ Gout

SKIN & BREAST
❑ Itching
❑ Blotchy
❑ Rash
❑ Scaling
❑ Sores
❑ Color changes
❑ Pain in breast
❑ Growths
❑ Lump or mass in breast or armpit
❑ Discharge or bleeding from nipple
❑ Change in nipple
❑ Nipple inversion
❑ Change in size, shape or contour of breast

NEUROLOGICAL
❑ Headaches
❑ Tremors
❑ Memory loss
❑ Difficulty finding words
❑ Difficulty writing
❑ Difficulty thinking clearly
❑ Numbness or tingling
❑ Dizziness
❑ Loss of consciousness
❑ Seizures
❑ Coordination
❑ Unsteady gait

PSYCHIATRIC
❑ Nervousness
❑ Anxiety
❑ Depression
❑ Change in personality
❑ Relationship problems

ENDOCRINE
❑ Excessive thirst
❑ Excessive urination
❑ Thyroid problems

HEMATOLOGIC & LYMPHATIC
❑ Swollen lymph glands
❑ Excessive bruising
❑ Excessive bleeding

ALLERGY & IMMUNOLOGY
❑ Medications
❑ Latex allergies
❑ Food or non-medication allergies
❑ Tape allergies
❑ Hay Fever
❑ None

ALLERGIES: ____

PAIN

Do you currently have any pain? ❑ Yes ❑ No If yes, where?______________________________

Please circle your current pain rating on a scale of 1-10 (1 being the best, or no pain. 10 being the worst, or intolerable).

1	2	3	4	5	6	7	8	9	10

Do you take medication for this pain? ❑ Yes ❑ No List:_______________________________

Is this medication effective for your pain? ❑ Yes ❑ No

Patient Name: ______________________________ Date: __________________

PATIENT SELF-ASSESSMENT

By placing a check in one box in each group below, please indicate which statements best describe your own health state today.

Mobility
- ❑ I have no problems in walking about
- ❑ I have some problems in walking about
- ❑ I am confined to bed

Self-Care
- ❑ I have no problems with self-care
- ❑ I have some problems washing or dressing myself
- ❑ I am unable to wash or dress myself

Usual Activities (e.g. work, housework, family, leisure activities)
- ❑ I have no problems with doing my usual activities
- ❑ I have some problems with doing my usual activities
- ❑ I am unable to perform my usual activities

Pain/Discomfort
- ❑ I have no pain and/or discomfort
- ❑ I have mild pain and/or discomfort
- ❑ I have moderate pain and/or discomfort
- ❑ I have severe pain and/or discomfort

Anxiety/Depression
- ❑ I am not anxious or depressed
- ❑ I am moderately anxious or depressed
- ❑ I am extremely anxious or depressed

Please draw a <u>single</u> circle or mark on the scale on the right (from 0 to 100) to demonstrate how you feel your overall health is today.