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

PAIN
Do you currently have any pain? ☐ Yes ☐ No
If yes, where?
Please circle your current pain level on a scale of 0-10 (0 being no pain and 10 being the worst pain, or intolerable).

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

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

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
☐ Mammogram

REVIEW OF SYSTEMS:
☐ Eyes
☐ Nose
☐ Throat
☐ Temperature
☐ Headache
☐ Pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Changes in bowel habits
☐ Blood in stool
☐ Color change of stool
☐ Jaundice
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Blood in stool
☐ Color change of stool

WOMEN ONLY
Age of Menarche ___ Age of Menopause ___
Date of last menstrual period: ______
Date of last pelvic exam: ______
Date of last pap: ______
Date of last pelvic exam: ______

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

MEN ONLY
☐ Testicular pain
☐ Testicular test
☐ Semen
☐ Urinary tract infection

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

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

NEUROLOGICAL
☐ Unsteady gait

REVIEW OF SYSTEMS:
☐ Headaches
☐ Tinnitus
☐ Memory loss
☐ Difficulty finding words
☐ Difficulty writing
☐ Difficulty thinking clearly
☐ Numbness or tingling
☐ Dizziness
☐ Loss of consciousness
☐ Seizures
☐ Coordination
☐ 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

MUSCULOSKELETAL
☐ Leg cramps
☐ Painful muscles
☐ Painful joints
☐ Articular joints
☐ Physical disabilities
☐ Gout

W:FORMS\PATIENT CHART AND INTAKE FORMS\Follow-Up Review of Systems (Mar2020).doc
Revised Mar2020