Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately .... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ **Eyes**
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses ... No Yes
- Blurred or double vision ..... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ..... No Yes
- Earaches or drainage ..... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste ..... No Yes
- Sore throat or voice change ... No Yes
- Swollen glands in neck ..... No Yes

☐ **Cardiovascular**
- Heart trouble ..... No Yes
- Chest pain or angina pectoris .. No Yes
- Palpitation ..... No Yes
- Shortness of breath w/walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Respiratory**
- Chronic or frequent coughs ... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath ..... No Yes
- Wheezing ..... No Yes

☐ **Gastrointestinal**
- Loss of appetite ..... No Yes
- Change in bowel movements .. No Yes
- Nausea or vomiting ..... No Yes
- Frequent diarrhea ..... No Yes
- Painful bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain ..... No Yes

☐ **Genitourinary**
- Frequent urination ..... No Yes
- Burning or painful urination .... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating ..... No Yes
- Incontinence or dribbling ..... No Yes
- Kidney stones ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods .... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal discharge ..... No Yes
- Female - # of pregnancies .... _____
- Female - # of miscarriages .... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles or joints .. No Yes
- Muscle pain or cramps ..... No Yes
- Back pain ..... No Yes
- Cold extremities ..... No Yes
- Difficulty in walking ..... No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching ..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails ..... No Yes
- Varicose veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump ..... No Yes
- Breast discharge ..... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy ..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations No Yes
- Tremors ..... No Yes
- Paralysis ..... No Yes
- Head injury ..... No Yes

☐ **Psychiatric**
- Memory loss or confusion ..... No
- Nervousness ..... No
- Depression ..... No
- Insomnia ..... No

☐ **Endocrine**
- Glandular or hormone problem No
- Excessive thirst or urination .... No
- Heat or cold intolerance ..... No
- Skin becoming dryer ..... No
- Change in hat or glove size .... No

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts ..... No
- Bleeding or bruising tendency .. No
- Anemia ..... No
- Phlebitis ..... No
- Past transfusion ..... No
- Enlarged glands ..... No

☐ **Allergic/Immunologic**

History of skin reaction or other adver reaction to:
- Penicillin or other antibiotics . No
- Morphine, Demerol, or other narcotics ..... No
- Novocain or other anesthetics No
- Aspirin or other pain remedies No
- Tetanus antitoxin or other serums ..... No
- Iodine, Merthiolate or other antiseptic ..... No
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inco information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical sta also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date