***code: GF004***

# REVIEW OF SYSTEMS

**First Name** ______________________ **Middle Name / MI** ______________________ **Last Name** ______________________

Check the box if you are **currently** experiencing any of the following:

**General**

- ☐ Arthritis/Rheumatism
- ☐ Back Pain (recurrent)
- ☐ Bone Fracture
- ☐ Cancer
- ☐ Diabetes
- ☐ Foot Pain
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Joint Injury
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Numbness/Tingling
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Weight Gain/Loss
- ☐ None

**Skin**

- ☐ Abnormal Pigmentation
- ☐ Boils
- ☐ Brittle Nails
- ☐ Dry Skin
- ☐ Eczema
- ☐ Frequent infections
- ☐ Hair/Nail changes
- ☐ Hives
- ☐ Itching
- ☐ Jaundice
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin Disease
- ☐ None

**Respiratory**

- ☐ Any Lung Troubles
- ☐ Asthma or Wheezing
- ☐ Bronchitis
- ☐ Chronic or Frequent Cough
- ☐ Difficulty Breathing
- ☐ Pleurisy or Pneumonia
- ☐ Spitting up Blood
- ☐ Trouble Breathing
- ☐ URI (Cold) Now
- ☐ None

**Cardiovascular**

- [ ] Awakening in the night smothering
- [ ] Chest Pain or Angina
- [ ] Congestive Heart Failure
- [ ] Cyanosis (blue skin)
- [ ] Difficulty walking two blocks
- [ ] Edema/Swelling of Hands, Feet or Ankles
- [ ] Heart Attacks
- [ ] Heart Murmur
- [ ] Heart Trouble
- [ ] High Blood Pressure
- [ ] Irregular Heartbeat
- [ ] Pain in legs
- [ ] Palpitations
- [ ] Poor Circulation
- [ ] Shortness of Breath
- [ ] Varicose Veins/Phlebitis
- [ ] None

**Gastrointestinal**

- [ ] Abdominal Pain
- [ ] Appetite Changes
- [ ] Black Stools
- [ ] Bleeding with Bowel Movements
- [ ] Blood in Vomit
- [ ] Chrohn’s Disease/Colitis
- [ ] Constipation
- [ ] Cramping or pain in the Abdomen
- [ ] Difficulty Swallowing
- [ ] Diverticulosis
- [ ] Frequent Diarrhea
- [ ] Gallbladder Disease
- [ ] Gas/Bloating
- [ ] Heartburn or Indigestion
- [ ] Hemorrhoids or Piles
- [ ] Hepatitis
- [ ] Hernia
- [ ] Liver Trouble
- [ ] Nausea/Vomiting
- [ ] Painful Bowel Movements
- [ ] Peptic Ulcer (Stomach or Duodenal)
- [ ] Recent change in Bowel habits
- [ ] None

**Eyes - Ears - Nose - Throat/Mouth**

- [ ] Blurring
- [ ] Double Vision
- [ ] Eye Disease or Injury
- [ ] Eye Pain/Discharge
- [ ] Glasses
- [ ] Glaucoma
- [ ] Itchy Eyes
- [ ] Vision changes
- [ ] Ear Disease
- [ ] Ear Infections
- [ ] Ears ringing
- [ ] Hearing problems
- [ ] Impaired Hearing
- [ ] Chronic Sinus Trouble
- [ ] Itchy Nose
- [ ] Nosebleeds
- [ ] Postnasal drip
- [ ] Sinusitis
- [ ] Sneezing or Runny Nose
- [ ] Gum Bleeding
- [ ] Hoarseness
- [ ] Loss of Taste
- [ ] Mononucleosis
- [ ] Sore Throat
- [ ] Sores
- [ ] None

**Genitourinary**

- [ ] Blood in Urine
- [ ] Bright’s Disease
- [ ] Burning or painful Urination
- [ ] Decrease in force/flow
- [ ] Frequent Urination
- [ ] Incontinence
- [ ] Kidney Stones
- [ ] Kidney Trouble
- [ ] Night time Urinating
- [ ] Prostate Problems
- [ ] None

**Hematologic**

- [ ] Abnormal Bruising or Bleeding
- [ ] Anemia
- [ ] Blood Disease
- [ ] Excessive Bleeding after tooth extraction
- [ ] Phlebitis
- [ ] Slow to heal
- [ ] None

**Endocrine**

- [ ] Become colder than before
- [ ] Changes in Hair Growth
- [ ] Changes in hat or glove size
- [ ] Fatigue Sweating/Night Sweats
- [ ] Fever/Chills
- [ ] Frequent infections
- [ ] Goiter
- [ ] Heat/cold intolerance
- [ ] Hormone Therapy
- [ ] Lymph node Enlargement
- [ ] Sleep Problems
- [ ] Thyroid Disease
- [ ] Weakness/Paralysis
- [ ] Weight Change
- [ ] None

**Neurological**

- [ ] Convulsions/Seizures
- [ ] Dizziness
- [ ] Fainting Spells
- [ ] Gait/Coordination
- [ ] Headaches/Migraines
- [ ] Paralysis
- [ ] Psychiatric Care
- [ ] Stroke
- [ ] Trauma
- [ ] Tremor/Hand Shaking
- [ ] None

## Mental Health

**Have you ever been diagnosed or treated for Depression and/or Anxiety?**

- Yes
- No

**Have you ever been diagnosed or treated for an Eating Disorder (e.g. anorexia/bulimia)?**

- Yes
- No

**Do you panic when stressed?**

- Yes
- No

**Do you have a problem with your appetite when under stress?**

- Yes
- No

**Do you cry frequently?**

- Yes
- No

**Have you ever attempted suicide?**

- Yes
- No

**Have you ever seriously thought about hurting yourself?**

- Yes
- No

**Do you have trouble sleeping?**

- Yes
- No

**Have you ever been to a counselor?**

- Yes
- No

**Have you been diagnosed or treated for Bi-Polar disorder?**

- Yes
- No

## Men Only

**Do you usually get up to urinate during the night?**

- Yes
- No

**Any loss of libido or sex drive?**

- Yes
- No

**Any blood in your urine?**

- Yes
- No

**Have you had any kidney, bladder, or prostate infections within the last 12 months?**

- Yes
- No

**Any difficulty with erection or ejaculation?**

- Yes
- No

## Women Only

**Heavy periods, irregularity, spotting, pain, or discharge?**

- Yes
- No

**Are you pregnant or breastfeeding?**

- Yes
- No

**Any hot flashes or sweating at night?**

- Yes
- No

**Do you have menstrual tension, bloating, irritability, or other symptoms at or around time of period?**

- Yes
- No

**Recurrent vaginal infections?**

- Yes
- No

**Pain/bleeding with sex?**

- Yes
- No

**Age at onset of menstruation:** ____________________

**Number of pregnancies:** ____________________

**Number of live births:** ____________________

**Number of miscarriages:** ____________________

**Number of abortions:** ____________________

**Date of last menstruation:** ____________________

**Length of cycle:** ____________________

**Days of flow:** ____________________

**Birth control method?** ____________________

**Date of last PAP** ____________________

**Date of last Mammogram** ____________________

## All Patients

**Is there anything that hasn't been covered above that you would like to add or explain?**

____________________________________________

### My signature indicates the above information is correct.

**Date:**

______________________________

**Signature of Patient (or Guardian/Authorized Representative):**

**Full Name of above signed (if not patient)**

__________________________________________

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.