



GENERAL REVIEW OF SYSTEMS

Reviewed By: _____

Name: _____ Birth Date: _____ Today's Date: _____

Have you ever had any of the conditions listed below? (check all that apply)

Table with 3 columns: Condition, Yes, Comments. Rows include GENERAL (Fatigue, Fever, Weight loss, Night sweats, Unexplained change), EYES (Glasses, Eye problems, Discharge), EARS, NOSE THROAT & MOUTH (Hearing, Allergies, Bleeds, Sinus, Hoarseness, CPAP, Drip, Apnea, Bleeding gums, Dental, Toothache), and RESPIRATORY (Cough, Sputum, Shortness of breath, Hemoptysis, Wheezing).

Last pulmonary function test: _____
Last chest x-ray: _____

Performed by/at: _____
Performed by/at: _____

	Yes	Comments
CARDIOVASCULAR		
Abnormally rapid heart rate (tachycardia)	_____	_____
Abnormally slow heart rate (bradycardia)	_____	_____
Blood clots in legs (DVT)	_____	_____
Chest pain or angina	_____	_____
Congenital heart defect	_____	_____
Excessive fluid retention/ankle swelling	_____	_____
Heart disease.....	_____	_____
Heart murmur	_____	_____
Heart pounding (palpitations)	_____	_____
History of Rheumatic fever	_____	_____
Shortness of breath with lying flat.....	_____	_____
Skipped or extra heart beats (arrhythmia)	_____	_____
Trouble breathing at night	_____	_____
Trouble climbing stairs.....	_____	_____
Varicose veins.....	_____	_____
Last electrocardiogram: _____	Performed by/at: _____	
Last stress test: _____	Performed by/at: _____	
Last cardiac catheterization: _____	Performed by/at: _____	

GASTROINTESTINAL		
Difficulty swallowing (dysphagia)	_____	_____
Frequent heart burn, indigestion	_____	_____
Vomiting or nausea (please circle which)	_____	_____
Vomiting blood (hematemesis)	_____	_____
Excessive belching (eructations)	_____	_____
Excessive passing of gas (flatus)	_____	_____
Food intolerance (please list foods)	_____	_____
Recent changes in bowel habits.....	_____	_____
Frequent diarrhea.....	_____	_____
Constipation.....	_____	_____
Rectal bleeding or blood in stools	_____	_____
Black stools (melena)	_____	_____
Irritable bowel or spastic colon	_____	_____
Recurrent abdominal pain (list where)	_____	_____
Jaundice, liver disease	_____	_____
Last upper GI (stomach x-ray): _____	Performed by/at: _____	
Last lower GI (barium enema x-ray): _____	Performed by/at: _____	

GENITOURINARY		
Blood in urine (hematuria)	_____	_____
Difficulty starting to urinate (hesitancy)	_____	_____
Dribbling urine	_____	_____
Frequent urination at night (nocturia) (list how many times)	_____	_____
History of herpes, venereal warts, HIV or other sexually transmitted disease (please circle)	_____	_____
Incontinence/leakage of urine	_____	_____
Painful urination or burning (dysuria)	_____	_____
Poor/weakened urine stream	_____	_____
Recurrent bladder or kidney infections (UTI) (circle which)	_____	_____
Last IVP/kidney x-ray: _____	Performed by/at: _____	
Last PSA level: _____	Performed by/at: _____	

WOMEN

Age at first menstrual cycle (menarche): _____ Date of last menstrual period: _____
 Age at time of first pregnancy: _____ Number of pregnancies: _____
 Number of miscarriages: _____ Age of menopause: _____
 Date of last pelvic exam and Pap smear: _____ Performed by/at: _____
 Results: _____

	Yes	Comments
Currently pregnant?	_____	_____
Irregular or heavy periods	_____	_____
Severe cramps or pain	_____	_____
Hormone therapy (please list number of years)	_____	_____

MEN

Pain or lumps in the testicles _____
 Problems initiating or maintaining an erection
 (erectile dysfunction) _____

INTEGUMENTARY/BREAST

Change in hair or nails (please describe) _____
 Change in mole or birthmark/location _____
 History of skin cancer (please list type & location) _____
 Skin rashes or itching (please circle which) _____
 Sores that will not heal _____

Breast discharge _____
 Breast infections _____
 Breast lumps _____
 Breast pain _____
 I perform monthly self breast exams _____

Last physician breast exam: _____ Performed at/by: _____
 Last mammogram: _____ Performed at by: _____

ENDOCRINE

Adrenal or pituitary gland disease (circle which)..... _____
 Excessive hunger _____
 Excessive thirst _____
 Excessive urination _____
 Glandular or hormonal problems _____
 Heat or cold tolerance (circle which) _____

NEUROLOGICAL

Black out spells _____
 Confusion _____
 Dizziness _____
 Frequent headaches _____
 Loss of coordination _____
 Memory loss _____
 Numbness or tingling sensation (where?)..... _____
 Paralysis _____
 Prior head injuries _____
 Tremors/twitches _____

	Yes	Comments
MUSCULOSKELETAL		
Amputations (location?)	_____	_____
Back pain	_____	_____
Broken Bones/fractures (where?)	_____	_____
Joint replacement – prosthesis (which joints?)	_____	_____
Joint stiffness/pain (which joints?)	_____	_____
Muscle pain or cramps (where?)	_____	_____
Muscle weakness (where?)	_____	_____

ALLERGIC/IMMUNOLOGIC/INFECTIOUS DISEASES		
Allergy to penicillin or other antibiotic (which)	_____	_____
Allergy to iodine, IVP or CT scan dye or shellfish (circle) .	_____	_____
Allergy to latex (please explain)	_____	<i>(please complete latex allergy questionnaire)</i>
Allergy to Novocain or other local anesthetic	_____	_____
Environmental allergies (dust, chemicals, soaps, household items, pollen, beestings, etc. – please list)	_____	_____
Food allergies (please list)	_____	_____
Usual childhood diseases (measles, mumps, chicken pox) .	_____	_____

HEMATOLOGIC/LYMPHATIC		
Anemia	_____	_____
Bleeding or bruising tendency	_____	_____
Blood clotting disorder	_____	_____
Enlarged glands or lymph nodes (where?)	_____	_____
Low platelet count (thrombocytopenia)	_____	_____

PSYCHIATRIC		
Alcohol abuse	_____	_____
Anxiety/nervousness.....	_____	_____
Depression	_____	_____
Do you have panic attacks?	_____	_____
Do you have suicidal thoughts or plans?	_____	_____
Drug abuse (please specify).....	_____	_____
Have you been under the care of a psychiatrist or psychologist.....	_____	_____
Unable to sleep (insomnia)	_____	_____

Signs and symptoms not covered above: _____

FOR OFFICE USE ONLY

I have reviewed these history forms in their entirety:

 Physician Signature Date

 Physician Signature Date