

REVIEW OF SYSTEMS

Check here if you have had this condition in the past

CARDIOVASCULAR

- High Blood Pressure
- Congenital heart disease
- Chest pain
- Heart murmur
- Mitral valve prolapse
- Shortness of breath during activity
- Swelling of feet, ankles or hands
- Heart attack
- Stroke
- Intermittent Claudication
- Deep venous thrombosis
- Phlebitis
- Congestive Heart Failure

RESPIRATORY

- Asthma
- Wheezing
- Tuberculosis
- Emphysema
- Pneumonia
- Chronic Obstructive Pulmonary Disease
- Frequent coughs

EAR, NOSE, MOUTH, THROAT AND EYES

- Hearing deficit
- Ringing in the ear
- Ear infection
- Visual deficit
- Glaucoma
- Cataracts
- Infection
- Nose Bleeds
- Polyps
- Sinusitis
- Recurrent Colds
- Loss of sense of smell
- Sores in mouth or tongue
- Dentures
- Sore throat (tonsillitis)
- Teeth of gum problems
- Difficulty swallowing

CURRENT MEDICATIONS

ALLERGIES TO MEDICATIONS AND FOODS:

Nurse's Signature _____

Check here if you have had this condition in the past

INTEGUMENTARY

- Eczema
- Itching
- Rashes
- Hair Loss
- Abnormal Scarring
- Changes in the nails
- Abnormal skin growth
- Changes in color
- Any abnormal growth or mass in the breasts

HEAD AND NECK

- Frequent Headaches
- Migraine
- Head injuries
- Vertigo
- Dizziness
- Fainting Spells

GASTROINTESTINAL

- Nausea and vomiting
- Diarrhea
- Constipation
- Ulcers
- Hepatitis, Type
- Cirrhosis of the liver
- Gall stones
- Hernias
- Hiatal hernia
- Blood in the stool
- Crohn's disease
- Colitis

GENITOURINARY

- Incontinence
- Kidney Stones
- Excessive urination
- Blood in the urine
- Veneral disease

MUSCULOSKELETAL

- Gout
- Pain in the joints which _____
- Joint stiffness which _____

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MUSCULOSKELETAL (CONT.)

- Rheumatoid Arthritis
- Degenerative joint disease
- Muscle Weakness which _____
- Muscle pain which _____
- Tremors
- Difficulty in walking

NEUROLOGICAL

- Seizures or convulsions
- Paralysis
- Numbness or tingling sensations
- Incoordination
- Poliomyelitis

HEMATOLOGICAL / LYMPHATIC

- Anemia
- Prolonged Bleeding
- Bruises easily
- Past transfusions
- Diabetes Mellitus
- how many years _____
- Thyroid Disease
- Intolerance to heat or cold
- Excessive sweating
- Excessive thirst
- Anorexia
- Recent weight gain or loss

PSYCHIATRIC

- Nervousness
- Anxiety
- Depression
- Insomnia
- Memory loss or confusion
- Do you have any psychiatric illness?

OB / GYN

- Gravida _____ Para _____
- Miscarriage _____
- Date of last PAP smear _____
- Date of last menses _____
- Are you pregnant? _____
- How many months _____
- IMMUNOLOGIC**
- AIDS or HIV - _____
- Recurrent infections _____ where _____

Pharmacy _____

Date _____