

Review of Systems (circle problems with any of the following)

- Yes No **Head, Ears and Eyes:** Do you currently have cataracts, glaucoma, glasses contacts, hearing aids, or experiencing any hearing loss or ringing in your ears?
- Yes No **Nose, Sinuses, Throat, and Mouth:** Do you currently have any problems with your ears, nose, or throat? Do you currently experience sleep apnea?
- Yes No **Skin:** Do you currently have herpes simplex, psoriasis, rashes, skin color changes, or skin infections?
- Yes No **Breast:** Do you have breast cancer, benign growths, or any other symptoms pertaining to your breasts?
- Yes No **Cardiovascular:** Do you currently have any cardiovascular symptoms, such as chest pain, palpitation, lightheadness, syncope, murmurs, hypertension, etc.?
- Yes No **Respiratory:** Do you currently have asthma, bronchitis, chest pain, emphysema/COPD, shortness of breath, tuberculosis, or a productive cough, etc.?
- Yes No **Gastrointestinal:** Do you currently have any gastrointestinal symptoms, such as cirrhosis, Crohns disease, diverticulitis, Hepatitis A, B, or C, hiatal hernia, pancreatitis, reflux, vomiting, ulcerative colitis, ulcers, diarrhea, constipation, rectal bleeding, hematochesia, etc.?
- Yes No **Genito-urinary:** Do you currently have any genito-urinary complaints, such as blood in urine, frequency, urgency, hesitancy, incontinence, kidney stones, etc.? Do you currently undergo dialysis? Have you had the loss of a kidney or a kidney transplant?
- Yes No **Gynecological:** Do you currently have any gynecological complaints such as vaginal bleeding, discharge, pain, etc.? Are you currently pregnant? If so, how many months pregnant?
- Yes No **Musculoskeletal:** Do you currently have any past or present problems related to the musculoskeletal system such as bone cancer, osteoporosis, lupus, rheumatoid arthritis, or degenerative joint disease?
- Yes No **Neurological/Psychiatric:** Do you currently have any problems related to the central nervous system, such as Alzheimers, epilepsy, brain aneurysm, brain surgery, depression, multiple sclerosis, paralysis, Parkinson's, Polio, seizures, stroke or stroke residual, etc.?
- Yes No **Hematologic and Lymphatic:** Do you currently have any problems with bruising, bleeding gums, adenopathy, blood transfusion, or anemia?
- Yes No **Vascular:** Do you currently have any problems with anemia, blood clots, hemophilia, varicose veins, or pulmonary embolus, sickle cell disease?
- Yes No **Endocrine:** do you currently have any problems with heat or cold intolerance, thyroid problems, hypercalcemia, polyuria, abnormal hair growth or loss, or skin changes?
- Yes No **Allergic and Immunologic:** do you currently have problems with allergic or immunologic organ systems?

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

Signature of Patient or Guardian

Date