Review of Systems / New Patient

NAME: (*Please Print*) ____
DATE: ____

Please check that which applies to your current condition

General: Weight change of 10 pounds or more in the last year____
Unusual weakness or loss of strength____ Fever____
Skin: Rashes, lumps, sores, itching, dryness, or color change____
Change in hair or nails____
Head: Frequent headaches____ Sinus pain or infection____
Head injury or concussion (past)____
Eyes: Vision changes____Pain/ redness____
Ear: Loss of hearing or ringing____
Nose: Frequent congestion, hay fever, or nosebleeds____
Mouth/Throat: Sore throat, difficulty swallowing____
Neck: Swollen glands, lumps, or pain____
Cardio: Chest pain, palpitations, or murmur____
Pulmonary: Wheezing or shortness of breath____ Chronic cough____
GI: Diarrhea/constipation____ Frequent gas/bloating____
Abdominal pain____ Frequent heartburn____ Rectal bleeding____
Urinary: Burning or pain____ History of frequent UTI____ Urgency/incontinence____
Wake >2x to urinate____
Women: Heavy bleeding____ Irregular cycles____Discharge____Last pap_______
Have you ever had an abnormal pap_____
Last menses or date of menopause______ Hotflashes _____
#Pregnancies____ #Live births____
Breast: Last mammogram______ Changes in breast appearance____
Men Only: Discharge or sores on penis____ Difficulty with erection____
Date of last prostate exam______ Testicular self-exam____
Vascular: Swelling in hand/legs/feet___ Cold hands/feet____
Musculoskeletal: Muscle/joint pain____ Leg cramps____
Last bone density test______
Neurologic: Numbness/tingling in your hands or feet____
Dizziness/faintness____ Tremors or shaking____
Endocrine/Blood: History of blood clots in your legs or lungs____
Excessive bruising or bleeding____ Heat/cold intolerance____
Mental/Emotional: Frequent feeling of anxiety or depression____

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