NAME _____ **DOB** _____ **PT#** _____ **DATE** _____

FAMILY HISTORY

Heart Disease _____	Hypertension _____	C.V.A. _____
Tuberculosis _____	Cancer _____	Diabetes _____
Kidney Disease _____	Anemia _____	Alcoholism _____
Stroke _____	Epilepsy _____	Other _____

REVIEW OF SYSTEMS

YES NO

☐ ☐ **GENERAL** Usual weight, recent weight change, any clothes that fit tighter or looser than before. Weakness, fatigue, fever _____

☐ ☐ **SKIN** Rashes, lumps, sores, itching, dryness, color change, changes in hair or nails _____

☐ ☐ **HEAD** Headache, head injury _____

☐ ☐ **EYES** Vision, glasses or contact lenses, last eye examination, pain, redness, excessive tearing, double vision, spots or specks, glaucoma, cataracts _____

☐ ☐ **EARS** Hearing, tinnitus, vertigo, earache, infection, discharge. If hearing is decreased, use of hearing aids _____

☐ ☐ **NOSE AND SINUSES** Frequent colds; nasal stuffiness, discharge, or itching; hay fever, nosebleeds, sinus trouble _____

☐ ☐ **MOUTH & THROAT** Condition of the throat and gums, bleeding gums, dentures, if any, and how they fit, last dental examination, sore tongue, dry mouth, frequent sore throat, hoarseness _____

☐ ☐ **NECK** Lumps, "swollen glands", goiter, pain or stiffness in neck _____

☐ ☐ **BREAST** Lumps, pain and discomfort, nipple discharge, self examination _____

☐ ☐ **RESPIRATORY** Cough, sputum (color quantity), hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy; last chest x-ray film _____

☐ ☐ **CARDIAC** Heart trouble, high blood pressure, rheumatic fever, heart murmurs; chest pain or discomfort, palpitations; dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema; past electrocardiogram or other heart tests _____

☐ ☐ **GASTROINTESTINAL** Trouble swallowing, heartburn, appetite, nausea, vomiting, regurgitation, vomiting of blood, indigestion. Frequency of bowel movements, color and size of stool, change in bowel habits, rectal bleeding, hemorrhoids, constipation, diarrhea. Abdominal pain, food intolerance, excessive belching or passing of gas. Jaundice, liver or gallbladder trouble, hepatitis _____

☐ ☐ **URINARY** Frequency of urination, polyuria, nocturia, burning or pain on urination, hematuria, urgency, reduced calibe or force of the urinary stream, hesitance, dribbling, incontinence; urinary infections, stones _____

☐ ☐ **GENITALS** *MALE:* Hernias, discharge from or sores in the penis, testicular pain or masses, history of sexually transmitted disease and their treatments. Sexual preference, interest, function, satisfaction, and problems _____ *FEMALE*: Age at menarche; regularity, frequency, and duration of periods; amount of bleeding, bleeding between periods or after intercourse, last menstrual period; dysmenorrheal, premenstrual tension; age at menopause, menopausal symptoms, postmenopausal bleeding. If the patient was born before 1971, exposure to DES (diethylstilbestrol) from maternal use during pregnancy. Discharge, itching, sores, lumps, sexually transmitted disease and their treatments. Number of pregnancies, sexual preference, interest, fuction, satisfaction; and problems, includin dyspareunia. _____

☐ ☐ **PERIPHERAL VASCULAR** Intermittent claudication, leg cramps, varicose veins, past clots in veins _____

☐ ☐ **MUSCULOSKELETAL** Muscle, joint pains, stiffness, arthritis, gout, backache. If present, describe location and system (e.g., swelling, redness, pain, tenderness, stiffness, weakness, limitation of motion or activity). _____

☐ ☐ **NEUROLOGIC** Fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling or "pins anc needles", tremors or other involuntary movements _____

☐ ☐ **HEMATOLOGIC** Anemia, easy bruising or bleeding, past transfusions and any reactions to them _____

☐ ☐ **ENDOCRINE** Thyroid trouble, heat or cold intolerance, excessive sweating; diabetes, excessive thirst or hunger, polyuria _____

☐ ☐ **PSYCHIATRIC** Nervousness, tension, mood including depression, memory _____