Name: _____ DOB:_____ Date:_____

Please Circle "Yes" or "No"

Review of Systems

Constitutional

Blood pressure:	Yes	No
Cholesterol:	Yes	No
Fever/Sweats:	Yes	No
Fatigue:	Yes	No
Loss of Appetite:	Yes	No
Weight Change:	Yes	No

Respiratory

Cough:	Yes	No
Spitting up blood:	Yes	No
Shortness of Breath:	Yes	No
Wheezing:	Yes	No

Eyes

Eye Disease/Injury:	Yes	No
Eye glasses/contacts:	Yes	No
Blurred/Double Vision:	Yes	No
Glaucoma/Cataracts:	Yes	No

Cardiovascular

Chest pain/Angina:	Yes	No
Palpitations:	Yes	No
Shortness of breath:	Yes	No
Murmur:	Yes	No
Irregular Heart Beat:	Yes	No
Swelling in Feet/Hands:	Yes	No

Gastrointestinal

Nausea:	Yes	No
Vomiting blood:	Yes	No
Rectal bleeding:	Yes	No
Blood in stool:	Yes	No
Abdominal Pain:	Yes	No
Heartburn:	Yes	No
Constipation:	Yes	No
Diarrhea:	Yes	No

Genitourinary

Frequent Urination:	Yes	No
Burning w/Urination:	Yes	No
Blood in Urine:	Yes	No
Kidney stones:	Yes	No

Neurological

Numbness/Tingling:	Yes	No
Headaches:	Yes	No
Stroke:	Yes	No
Blackout spells:	Yes	No
Head Injury:	Yes	No
Seizures:	Yes	No

Ears/Nose/Mouth/Throat

Hearing loss:	Yes	No
Ringing noise in ears:	Yes	No
Earaches and drainage:	Yes	No
Trouble swallowing:	Yes	No
Frequent colds:	Yes	No
Seasonal allergies:	Yes	No
Problems w/Thyroid:	Yes	No

Musculoskeletal

Joint Pain/stiffness:	Yes	No
Muscle pain/cramps:	Yes	No
Muscle weakness	Yes	No
Legs hurt when walking:	Yes	No

Skin

Rashes:	Yes	No
Lesions:	Yes	No
Ulcers:	Yes	No
Cancer	Yes	No

Hematologic/Lymphatic

Bleed/bruise easy:	Yes	No
Blood clots:	Yes	No
Past blood transfusion:	Yes	No
Cuts slow to heal:	Yes	No

Other Systems

Memory loss/Confusion:	Yes	No
Nervousness/Anxiety:	Yes	No
Depression:	Yes	No
HIV:	Yes	No
Tuberculosis:	Yes	No

Past Medical History

Cardiovascular

Hypertension:	Yes	No
High Cholesterol:	Yes	No
Chest pain/Angina:	Yes	No
Mitral Valve Prolapse:	Yes	No
Valve problems:	Yes	No
Palpitations:	Yes	No
Murmur:	Yes	No
Pacemaker/Defibulator:	Yes	No
Heart Attack:	Yes	No
Rapid heartbeat:	Yes	No
Slow heart beat:	Yes	No

Respiratory

Emphysema:	Yes	No
Asthma:	Yes	No
Pneumonia:	Yes	No
Black lung disease:	Yes	No
COPD:	Yes	No

Gastrointestinal

Ulcers:	Yes	No
Hiatal hernia:	Yes	No
Gallstones:	Yes	No
Pancreatitis:	Yes	No

Genitourinary

Kidney stones:	Yes	No
Kidney failure:	Yes	No
Dialysis:	Yes	No
Prostate:	Yes	No

Neurological

Frequent headaches:	Yes	No
Stroke:	Yes	No
Seizures:	Yes	No

Other

Thyroid:	Yes	No
Arthritis:	Yes	No
Gout:	Yes	No
Diabetic:	Yes	No

Past Surgeries/Procedures

Stent Placement: □Heart □Other		
Valve Surgery:	Yes	No
Aneurysm Surgery:	Yes	No
Angioplasty (balloon):	Yes	No
Bypass Surgery: □ Heart	Yes	No
□ Leg	Yes	No
Carotid Artery Surgery:	Yes	No

Other Surgeries

_____

_____

_____

Social History

□ Single □ Married □ Divorced □ Widow

Children #:_____

Education:_____

Occupation: _____

Retired:_____ Disabled: _____

Date:_____

Tobacco: □ Chew □ Smoke

packs/day:_____

Coffee: # cups/day: _____

Caffeinated soda: # cans/day:_____

Alcohol:_____

Family History

Heart Attack:
□ Mother □ Father □ Sibling(s)

Chest Pain/Angina:
□ Mother □ Father □ Sibling(s)

Bypass Surgery:
□ Mother □ Father □ Sibling(s)

Valve Surgery:
□ Mother □ Father □ Sibling(s)

Stent Placement:
□ Mother □ Father □ Sibling(s)

Pacemaker/ICD:
□ Mother □ Father □ Sibling(s)

Abnormal Heart Beat:
□ Mother □ Father □ Sibling(s)

High Blood Pressure:
□ Mother □ Father □ Sibling(s)

Stroke(s):
□ Mother □ Father □ Sibling(s)

Diabetic:
□ Mother □ Father □ Sibling(s)