Pt Name:______________________________ D.O.B.__________________ Date:____________

Review of Systems & Medical History

Past Medical History: ____

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Past Surgical History: ____

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Family History: ____

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Do you have chronic problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms		
Fever/Chills	Y	N
Weight loss	Y	N
Headache	Y	N
Other ________________________		
Eyes		
Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other________________________		
Allergic/Immunologic		
Hay Fever	Y	N
Drug allergies (please list on separate page)	Y	N
Other________________________		
Neurological		
Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other________________________		
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other________________________		
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Hepititis/Liver disease	Y	N
Other ________________________		
Cardiovascular		
Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Heart Disease	Y	N
Other________________________		

Integumentary		
Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other ________________________		
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other ________________________		
Ear/Nose/Throat/Mouth		
Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other ________________________		
Genitourinary		
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other ________________________		
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other ________________________		
Hematologic/Lymphatic		
Swollen glands	Y	N
Blood clotting problem	Y	N
Blood Transfusions	Y	N
Blood Diseases	Y	N
Other________________________		
Psychologic		
Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other ________________________		

Do you smoke? Y N If yes, how long?________________________

Do you drink alcohol? Y N If yes, how long?________________________

Is there a history of prostate cancer in your family? Y N

Is there a history of bladder cancer in your family? Y N

Is there a history of kidney stones in your family? Y N

If you are female, are you pregnant? Y N Date of late menstrual period__________________