

**REVIEW OF SYSTEMS** (Please check the box if you have)

G68(3)-0804

**CARDIOVASCULAR SYSTEM**

- CHEST PAIN WITH ACTIVITY \_\_\_\_\_
- HEART MURMUR/HEART VALVE DISEASE \_\_\_\_\_
- SHORT OF BREATH \_\_\_\_\_
- SHORTNESS OF BREATH ON ACTIVITY \_\_\_\_\_
- SKIPPING HEARTBEAT OR RACING \_\_\_\_\_
- SWELLING ANKLES OR HANDS \_\_\_\_\_
- TROUBLE BREATHING LYING FLAT \_\_\_\_\_
- TROUBLE BREATHING WHILE SLEEPING \_\_\_\_\_

**CENTRAL NERVOUS SYSTEM**

- DIZZINESS \_\_\_\_\_
- DROWSINESS \_\_\_\_\_
- NUMBNESS/TINGLING IN ARMS OR LEGS \_\_\_\_\_
- RECURRING HEADACHES \_\_\_\_\_
- TEMPORARY LOSS OF VISION (in one eye) \_\_\_\_\_
- WEAKNESS IN ARMS OR LEGS \_\_\_\_\_

**DERMATOLOGY**

- RASH \_\_\_\_\_
- SKIN CHANGES \_\_\_\_\_

**ENDOCRINE**

- FREQUENT HUNGER \_\_\_\_\_
- FREQUENT THIRST \_\_\_\_\_
- HEAT/COLD INTOLERANCE \_\_\_\_\_

**GASTROINTESTINAL**

- ABDOMINAL PAIN \_\_\_\_\_
- CONSTIPATION \_\_\_\_\_
- DIARRHEA \_\_\_\_\_
- DIVERTICULOSIS \_\_\_\_\_
- FATTY FOOD INTOLERANCE \_\_\_\_\_
- HEARTBURN \_\_\_\_\_
- HX: GALL STONES \_\_\_\_\_
- HX: ULCERS \_\_\_\_\_
- LOSS OF APPETITE \_\_\_\_\_
- NAUSEA/VOMITING \_\_\_\_\_
- RECTAL BLEEDING/BLOOD IN STOOL \_\_\_\_\_
- TROUBLE SWALLOWING \_\_\_\_\_
- WEIGHT LOSS \_\_\_\_\_

**HEAD, EYES, EARS, NOSE, THROAT**

- BLINDNESS \_\_\_\_\_
- DEAFNESS \_\_\_\_\_
- DIZZINESS/LOSS OF BALANCE \_\_\_\_\_
- HOARSENESS \_\_\_\_\_
- NOSEBLEED \_\_\_\_\_
- RINGING IN EAR \_\_\_\_\_
- RUNNY NOSE \_\_\_\_\_

**HEMATOLOGY**

- ANEMIA \_\_\_\_\_
- BLOOD DISEASE (like hemophilia, hepatitis, HIV, sickle cell) \_\_\_\_\_
- EASY BRUISING \_\_\_\_\_
- TRANSFUSIONS (Recent) \_\_\_\_\_

**MUSCULOSKELETAL**

- ARTHRITIS \_\_\_\_\_
- BACK PAIN \_\_\_\_\_
- PAIN IN JOINTS \_\_\_\_\_
- PAIN IN THE LEGS WHILE WALKING / RESTING \_\_\_\_\_
- SWELLING OF LEGS \_\_\_\_\_

**PSYCHOLOGICAL**

- ANXIETY \_\_\_\_\_
- DEPRESSION \_\_\_\_\_
- MOOD CHANGES \_\_\_\_\_
- TENSION \_\_\_\_\_

**RESPIRATORY SYSTEM**

- ABNORMAL COLORED MUCOUS \_\_\_\_\_
- COUGH \_\_\_\_\_
- COUGH UP BLOOD \_\_\_\_\_
- WHEEZING \_\_\_\_\_

**URINARY**

- DRIBBLING (Urination) \_\_\_\_\_
- FREQUENCY \_\_\_\_\_
- HESITANCY (Urination) \_\_\_\_\_
- PAINFUL URINATION \_\_\_\_\_
- URINATION AT NIGHT \_\_\_\_\_

**ADDITIONAL COMMENTS**

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This history information is true and accurate to the best of my knowledge.

DATE \_\_\_\_\_

PATIENT SIGNATURE (parent if patient is a minor)

STAFF WITNESS