CENTERS ANKLE & FOOT OF MISSOURI

Patient Review Of Systems

(Please Circle)

Patient's Name _____

Date of Birth _____

EARS / NOSE / THROAT:		
Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problems	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO
CARDIOVASCULAR:		
Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitations	YES	NO
Swelling of ankles or hands	YES	NO
ENDOCRINE:		
Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes (insulin / non-insulin)	YES	NO
Excessive thirst / urination	YES	NO
Heat or cold intolerance	YES	NO
NEUROLOGICAL:		
Frequent / recurring headaches	YES	NO
Light headed or dizziness	YES	NO
Convulsions or seizures	YES	NO
Numbness or tingling	YES	NO
Shakes, paralysis, trembling	YES	NO
Stroke or head injury	YES	NO
PSYCHIATRIC:		
Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Difficulty sleeping	YES	NO
HEMATOLOGIC / LYMPHATIC:		
Slow to heal after cuts	YES	NO
Bleeding /bruising tendency	YES	NO
Anemia	YES	NO
Blood clot / transfusions	YES	NO
Enlarged glands	YES	NO
GENERAL:		
Recent weight changes	YES	NO
Fever or night sweats	YES	NO
Fatigue or weakness	YES	NO
MUSCULOSKELETAL:		
Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness in muscles /joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Difficulty walking	YES	NO
Breast pain or lump	YES	NO
Nipple discharge	YES	NO
GENITOURINARY:		
Frequent urination	YES	NO
Burning / painful urination	YES	NO
Awaken at night to urination	YES	NO
Blood in urine	YES	NO
Change in urine stream force	YES	NO
Incontinence or dribbling	YES	NO
Sores or discharge	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male only:		
Testicle pain /lumps	YES	NO
Female only:		
Painful periods	YES	NO
Irregular periods	YES	NO
Vaginal discharge	YES	NO
Number of pregnancies	_____	
Number of miscarriages	_____	
Date of last pap smear	_____	
Date of last mammogram	_____	
EYES:		
Eye disease or injury	YES	NO
Wear glasses / contact lens	YES	NO
Blurred or double vision	YES	NO
Glaucoma or cataracts	YES	NO
Date of last eye exam	_____	
RESPIRATORY:		
Chronic or frequent coughs	YES	NO
Spitting up of blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO
GASTROINTESTINAL:		
Loss of appetite	YES	NO
Change in bowel habits	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Constipation	YES	NO
Painful bowel movements	YES	NO
Blood in stool	YES	NO
Abdominal pain	YES	NO
Ulcer (stomach / duodenal)	YES	NO
INTEGUMENTARY:		
Rash or itching	YES	NO
Change in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
OTHER:		
Hepatitis	YES	NO
HIV	YES	NO

Doctor's Signature _____ Date _____