PATIENT HISTORY FORM – REVIEW OF SYSTEMS

NAME: _____ DATE: _____

HEIGHT _____ FEET_____ INCHES WEIGHT _____ LBS

UROLOGY

FREQUENT URINATION	□ YES	□ NO
URGENT NEED TO URINATE	□ YES	□ NO
PAIN WITH URINATION	□ YES	□ NO
NIGHTTIME URINATION	□ YES	□ NO
DIFFICULTY STARTING URINARY STREAM	□ YES	□ NO
LEAKAGE OR DRIBBLING	□ YES	□ NO
REDUCED FLOW	□ YES	□ NO
BLOOD IN URINE	□ YES	□ NO
STRAINING TO URINATE	□ YES	□ NO
PELVIC PAIN	□ YES	□ NO
IRREGULAR PERIODS	□ YES	□ NO
POST MENOPAUSAL	□ YES	□ NO
DATE OF LAST MENSTRUAL PERIOD	____ / ____ / ____	
CURRENTLY ON HORMONE REPLACEMENT ?	□ YES	□ NO

IF YES, _____

MALE REPRODUCTIVE

DIFFICULTY WITH ERECTION	□ YES	□ NO
DIFFICULTY WITH EJACULATION	□ YES	□ NO
DIMINISHED SEXUAL DRIVE	□ YES	□ NO

CARDIOLOGY

SWELLING OF ANKLES	□ YES	□ NO
SHORTNESS OF BREATH	□ YES	□ NO
CHEST PAIN WITH EXERTION	□ YES	□ NO
DIZZINESS	□ YES	□ NO
IRREGULAR HEARTBEAT	□ YES	□ NO
PALPITATIONS	□ YES	□ NO

DERMATOLOGY

SCARS	□ YES	□ NO
RASH	□ YES	□ NO
DRY OR SENSITIVE SKIN	□ YES	□ NO
HIVES	□ YES	□ NO
ACNE	□ YES	□ NO
SKIN CANCER	□ YES	□ NO

ENDOCRINOLOGY

FATIGUE	□ YES	□ NO
EXCESSIVE THIRST	□ YES	□ NO
EXCESSIVE URINATION	□ YES	□ NO
COLD INTOLERANCE	□ YES	□ NO
HOT FLASHES	□ YES	□ NO
WEIGHT GAIN	□ YES	□ NO
WEIGHT LOSS	□ YES	□ NO
FEVER	□ YES	□ NO
CHILLS	□ YES	□ NO
WEAKNESS	□ YES	□ NO

ENT

DIFFICULTY SWALLOWING	□ YES	□ NO
SORE THROAT	□ YES	□ NO
COUGH	□ YES	□ NO
SINUS PROBLEMS	□ YES	□ NO
HEARING LOSS / DIFFICULTY HEARING	□ YES	□ NO
NOSE BLEEDS	□ YES	□ NO
TINNITIS (RINGING IN EAR)	□ YES	□ NO

GASTROENTEROLOGY

ADOMINAL PAIN	□ YES	□ NO
CONSTIPATION	□ YES	□ NO
NAUSEA / VOMITING	□ YES	□ NO
HEARTBURN / INDIGESTION	□ YES	□ NO
DIARRHEA	□ YES	□ NO
BLOOD IN STOOL	□ YES	□ NO

HEMATOLOGIC / LYMPHATIC

BRUSIES EASILY	□ YES	□ NO
SWOLLEN LYMPH NODES	□ YES	□ NO
BLOOD CLOTTING PROBLEM	□ YES	□ NO
LOSS OF APPETITE	□ YES	□ NO

MUSCULOSKELETAL

FRACTURE	□ YES	□ NO
BACK PAIN	□ YES	□ NO
MUSCLE WEAKNESS	□ YES	□ NO
JOINT SWELLING, STIFFNESS, PAIN	□ YES	□ NO

NEUROLOGY

INSOMNIA	□ YES	□ NO
DIZZINESS	□ YES	□ NO
WEAKNESS	□ YES	□ NO
HEADACHE	□ YES	□ NO
NUMBNESS / TINGLING	□ YES	□ NO
SEIZURES / CONVULSIONS	□ YES	□ NO
LEG WEAKNESS	□ YES	□ NO

OPTHAMOLOGY

BLURRING OF VISION	□ YES	□ NO
EYE IRRITATION / PAIN	□ YES	□ NO
LOSS OF VISION	□ YES	□ NO
SPOTS IN VISION	□ YES	□ NO

RESPIRATORY

SHORTNESS OF BREATH	□ YES	□ NO
NEED FOR HOME OXYGEN	□ YES	□ NO
COUGH	□ YES	□ NO

OTHER : _____