Review of Systems: Please indicate your personal history below:

Constitutional Symptoms			Genitourinary			Psychiatric		
Good general health	no	yes	Frequent urination	no	yes	Memory loss or confusion	no	yes
Recent weight change	no	yes	Burning or painful urination	no	yes	Nervousness	no	yes
Fever	no	yes	Blood in urine	no	yes	Depression	no	yes
Fatigue	no	yes	Strain when urinating	no	yes	Insomnia	no	yes
Headaches	no	yes	Incontinence or dribbling	no	yes	**Endocrine**		
Eyes			Kidney stones	no	yes	Glandular/ hormone problem	no	yes
Eye disease or injury	no	yes	Sexual difficulty	no	yes	Excessive thirst or urination	no	yes
Wear glasses/ contact lenses	no	yes	Male-testicle pain	no	yes	Heat or cold intolerance	no	yes
Blurred or double vision	no	yes	Female-pain with periods	no	yes	Skin becoming dryer	no	yes
Ears/Nose/Throat			Female-irregular periods	no	yes	Change in hat or glove size	no	yes
Hearing loss or ringing	no	yes	Female-vaginal discharge	no	yes	**Hematologic/Lymphatic**		
Earaches or drainage	no	yes	Female-# of pregnancies			Slow to heal after cuts	no	yes
Chronic sinus problem	no	yes	Female-# of miscarriages			Bleeding or bruising tendency	no	yes
Nose bleeds	no	yes	Female-date of last pap smear			Anemia	no	yes
Mouth sores	no	yes	**Musculoskeletal**			Phlebitis	no	yes
Bleeding gums	no	yes	Joint pain	no	yes	Past transfusion	no	yes
Bad breath or bad taste	no	yes	Joint stiffness or swelling	no	yes	Enlarged glands	no	yes
Sore throat or voice change Chronic rhinitis	no no	yes yes	Weakness of muscles or joints	no	yes	**Allergic/Immunologic** History of skin reaction Or other adverse reaction to :		
Swollen glands in neck	no	yes	Muscle pain or cramps	no	yes	Penicillin	no	yes
Cardiovascular			Back pain	no	yes	Any other antibiotic	no	yes
Heart trouble	no	yes	Cold extremities	no	yes	Name of antibiotic		
Chest pain or angina pectoris	no	yes	Difficulty in walking	no	yes	Demerol	no	yes
Palpitation	no	yes	**Integumentary (skin, breast)**			Codeine	no	yes
Shortness of breath	no	yes	Rash or itching	no	yes	Any other narcotic	no	yes
Swelling of feet, ankles or hands	no	yes	Change in skin color	no	yes	Name of narcotic		
Respiratory			Change in hair or nails	no	yes	Novocain or other anesthetics	no	yes
Do you have a persistent cough	no	yes	Varicose veins	no	yes	Aspirin or other pain remedies	no	yes
Spitting up blood	no	yes	Breast pain	no	yes	Tetanus antitoxin or other serums	no	yes
Shortness of breath	no	yes	Breast lump	no	yes	Iodine, Merthiolate or other antiseptic	no	yes
Wheezing	no	yes	Breast discharge	no	yes	Other drugs/medications Please list:	no	yes
Gastrointestinal			**Neurological**					
Loss of appetite	no	yes	Frequent or recurring headaches	no	yes			
Change in bowel movements	no	yes	Light headed or dizzy	no	yes			
Nausea or vomiting	no	yes	Convulsions or seizures	no	yes			
Frequent diarrhea	no	yes	Numbness or tingling sensations	no	yes	Known food allergies please list:	no	yes
Painful bowel movements or constipation	no	yes	Tremors	no	yes			
Rectal bleeding or blood in stool	no	yes	Paralysis	no	yes	Environmental allergies Please list-	no	yes
Abdominal pain	no	yes	Head injury	no	yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

________________________________ ________________________________

Signature of Patient, Parent or Guardian Date

Doctor's Review

________________________________ ________________________________

Signature of Doctor Date