Review Of Systems

Please check all that apply:

☐ Kidney Disease: CKD Stage_____ Dialysis: ☐ PD ☐ HD ☐ Transplant ☐ Acute Kidney Injury
☐ Diabetes: ☐ Type 1 Or ☐ Type 2
☐ High Blood Pressure
☐ Heart Disease
☐ Cancer: Type_____ Year diagnosed:_____
☐ Stroke
☐ Gout

EENT:	☐ Blindness	☐ Hearing Problems/Hearing Loss
	☐ Cataracts	☐ Glaucoma
Cardiovascular:	☐ Atrial Fibrillation(A-Fib)	☐ Damaged/Defective Heart Valve
	☐ Pacemaker/Defibrillator	☐ Congestive Heart Failure (CHF)
	☐ High Cholesterol	☐ Mitral Valve Prolapse (MVP)
Respiratory:	☐ COPD	☐ Pneumonia
	☐ Chronic Bronchitis	☐ Tuberculosis (TB)
	☐ Asthma	☐ Sleep Apnea
	☐ Emphysema	
Gastrointestinal:	☐ Acid Reflux (GERD)	☐ Inflammatory Bowel Disease (IBD)
	☐ Stomach/Bowel Ulcers	☐ Irritable Bowel Disease (IBS)
	☐ Gall Bladder Disease	☐ Gluten Intolerance
	☐ Hepatitis	☐ Lactose Intolerance
Genitourinary:	☐ Enlarged Prostate	☐ Kidney Stones
	☐ Frequent Urinary Tract Infections	
OB History:	☐ Preeclampsia	☐ Gestational Diabetes
	☐ Complications during pregnancy	
Musculoskeletal:	☐ Osteoarthritis	☐ Osteoporosis
Neurological:	☐ Multiple Sclerosis	☐ Parkinson's
	☐ Seizures	☐ Dementia
Psychiatric:	☐ Depression	☐ Anxiety
Endocrine:	☐ Underactive Thyroid	☐ Overactive Thyroid
	☐ Hyperparathyroidism	☐ Adrenal Insufficiency
Hematology:	☐ Anemia	☐ Sickle Cell Trait
	☐ Sickle Cell Disease	☐ Blood Transfusion
Immuno:	☐ HIV/AIDS	☐ Lupus

- Medication Allergies : _____
- Pharmacy : _____

Review Of Systems

Please Check all that apply and list year of surgery if possible.

☐ Appendectomy_____
☐ CABG_____
☐ Cataract Removal_____
☐ Gall Bladder_____
☐ Gastric Bypass_____
☐ Hernia Repair_____
☐ C-Section_____
☐ Other_____

☐ Hip Replacement: Left_____Right_____
☐ Knee Replacement: Left_____Right_____
☐ Hysterectomy: Full_____Partial_____
☐ Nephrectomy_____
☐ Kidney Transplant_____
☐ Tonsillectomy_____
☐ Thyroidectomy_____

_____
_____
_____

Review Of Systems

Please check all that apply:

Illness:	Mother	Father	Siblings	Children
Kidney Disease				
Diabetes				
High Blood Pressure				
Heart Disease				
Cancer				
Stroke				
Gout				
Dementia				
Polycystic Kidneys				

Mother: ☐ Living ☐ Deceased
Father: ☐ Living ☐ Deceased

Review Of Systems

Please check all that apply:

Tobacco Usage: ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff ☐ Former User ☐ N/A
Frequency: ☐ Everyday ☐ Some days
Packs Per Day:_____ Years Smoked:_____
Year Started_____Year Quit:_____
Alcohol Usage: ☐ Current User ☐ Former User ☐ Never Used
☐ Occasional Social Drink ☐ 1-3 Drinks per day ☐ 3 or more drinks per day
Recreational Drug use: ☐ Current User ☐ Former User ☐ Never Used
Type of Drug:_____

Review Of Systems

Name: _____

In the last 30 days, Have you had any of the following symptoms?

Please check all that apply:

Constitutional: ☐ Fever ☐ Fatigue ☐ Abnormal weight loss/gain
☐ Chills ☐ General weakness ☐ Swelling, if so where?:_____

HEENT: ☐ Eye pain ☐ Redness ☐ Color blindness ☐ Double Vision
☐ Earaches ☐ Sore throat ☐ Hoarseness ☐ Frequent Headaches
☐ Sinus problems ☐ Dizziness/Vertigo

Respiratory: ☐ Shortness of breath ☐ Coughing ☐ Wheezing
☐ Shortness of breath at rest ☐ Painful breathing ☐ Night sweats
☐ Shortness of breath with activity ☐ Coughing up blood

Cardiovascular: ☐ Chest Pains ☐ Palpitations(heart fluttering) ☐ Leg Pain(Claudication)
☐ Difficulty breathing when laying flat(Orthopnea)

Gastrointestinal: ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Indigestion
☐ Diarrhea ☐ Constipation ☐ Trouble Swallowing

Genitourinary: ☐ Urinary Urgency ☐ Burning or pain with urination ☐ Incontinence
☐ Blood or foam in urine ☐ Urinary Frequency ☐ Urinary Hesitancy
☐ Excessive urination at night (Nocturia)

Musculoskeletal: ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle pain
☐ Arm weakness ☐ Leg weakness

Skin: ☐ Rash ☐ Itching ☐ Dryness ☐ Scaling ☐ Color change

Neurological: ☐ Numbness, if so where?_____ ☐ Tremors
☐ Tingling, if so where?_____ ☐ Fainting/Blackouts

Psychiatric: ☐ Depression ☐ Anxiety ☐ Insomnia (sleep disorder)

Endocrine: ☐ Excessive Thirst ☐ Excessive Urination
☐ Heat Intolerance (sensitive to hot temperatures)
☐ Cold Intolerance (sensitive to cold temperatures)

Hematology: ☐ Bruise easily ☐ Gums bleeding often

Immuno/Allergy: ☐ Hives (rash, red bumps/welts on skin) ☐ Seasonal Allergies

Please list any additional symptoms if they are not listed above: _____
_____
_____
_____

Have you received a **Flu** shot within the last 12 months? Yes No

Have you received a **Pneumonia** shot within the last 10 years? Yes No