

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.

- | | |
|---|---|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hip Replacement: Left _____ Right _____ |
| <input type="checkbox"/> CABG _____ | <input type="checkbox"/> Knee Replacement: Left _____ Right _____ |
| <input type="checkbox"/> Cataract Removal _____ | <input type="checkbox"/> Hysterectomy: Full _____ Partial _____ |
| <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Nephrectomy _____ |
| <input type="checkbox"/> Gastric Bypass _____ | <input type="checkbox"/> Kidney Transplant _____ |
| <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> C-Section _____ | <input type="checkbox"/> Thyroidectomy _____ |
| <input type="checkbox"/> Other _____ | |

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: _____

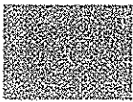
Year Started _____ Year Quit: _____

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: _____



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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