## PATIENT HISTORY FORM

# REVIEW OF SYMPTOMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.

**Please explain any Yes answers in space provided.**

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Unexplained weight change | Y | N |

Other _____

**Allergic/Immunologic**

| | | |
|---|---|---|
| Drug allergies | Y | N |

Other _____

**Eyes**

| | | |
|---|---|---|
| Acute vision change | Y | N |

Other _____

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |

Other _____

**Neurological**

| | | |
|---|---|---|
| Weakness | Y | N |
| Dizzy spells | Y | N |
| Numbness/tingling | Y | N |

Other _____

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain | Y | N |
| High blood pressure | Y | N |
| Known Heart problems | Y | N |

Other _____

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |

Other _____

**Psychiatric**

| | | |
|---|---|---|
| Depression | Y | N |

Other _____

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Constipation | Y | N |
| Fecal incontinence (leakage) | Y | N |

Other _____

**Genitourinary**

| | | |
|---|---|---|
| Urine retention (can't void) | Y | N |
| Urine incontinence (leakage) | Y | N |
| Urinary frequency | Y | N |
| Painful urination | Y | N |

Other _____

**Musculoskeletal**

| | | |
|---|---|---|
| Neck pain | Y | N |
| Back pain | Y | N |

Other _____

**Integumentary**

| | | |
|---|---|---|
| Skin rash | Y | N |
| Genital Lesion | Y | N |

Other _____

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | Y | N |
| Tired or sluggish | Y | N |

Other _____

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |

Other _____

**I have read through the full form and answered "YES" to any applicable systems. All unmarked systems are "NO". Patient signature** _____