

code: GF004

## REVIEW OF SYSTEMS

First Name

Middle Initial

Last Name

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Check the box if you are **currently** experiencing any of the following:

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### General

- Arthritis/Rheumatism
- Back Pain (recurrent)
- Bone Fracture
- Cancer
- Diabetes
- Foot Pain
- Gout
- Headaches/Migraines
- Joint Injury
- Memory Loss
- Muscle Weakness
- Numbness/Tingling
- Obesity
- Osteoporosis
- Rheumatic Fever
- Weight Gain/Loss
- None

### Skin

- Abnormal Pigmentation
- Boils
- Brittle Nails
- Dry Skin
- Eczema
- Frequent infections
- Hair/Nail changes
- Hives
- Itching
- Jaundice
- Psoriasis
- Rash
- Skin Disease
- None

### Respiratory

- Any Lung Troubles
- Asthma or Wheezing
- Bronchitis
- Chronic or Frequent Cough
- Difficulty Breathing
- Pleurisy or Pneumonia
- Spitting up Blood
- Trouble Breathing
- URI (Cold) Now
- None

**Cardiovascular**

- Awakening in the night smothering
- Chest Pain or Angina
- Congestive Heart Failure
- Cyanosis (blue skin)
- Difficulty walking two blocks
- Edema/Swelling of Hands, Feet or Ankles
- Heart Attacks
- Heart Murmur
- Heart Trouble
- High Blood Pressure
- Irregular Heartbeat
- Pain in legs
- Palpitations
- Poor Circulation
- Shortness of Breath
- Varicose Veins/Phlebitis
- None

**Gastrointestinal**

- Abdominal Pain
- Appetite Changes
- Black Stools
- Bleeding with Bowel Movements
- Blood in Vomit
- Crohn's Disease/Colitis
- Constipation
- Cramping or pain in the Abdomen
- Difficulty Swallowing
- Diverticulosis
- Frequent Diarrhea
- Gallbladder Disease
- Gas/Bloating
- Heartburn or Indigestion
- Hemorrhoids or Piles
- Hepatitis
- Hernia
- Liver Trouble
- Nausea/Vomiting
- Painful Bowel Movements
- Peptic Ulcer (Stomach or Duodenal)
- Recent change in Bowel habits
- None

**Eyes - Ears - Nose - Throat/Mouth**

- Blurring
- Double Vision
- Eye Disease or Injury
- Eye Pain/Discharge
- Glasses
- Glaucoma
- Itchy Eyes
- Vision changes
- Ear Disease
- Ear Infections
- Ears ringing
- Hearing problems
- Impaired Hearing
- Chronic Sinus Trouble
- Itchy Nose
- Nosebleeds
- Postnasal drip
- Sinusitis
- Sneezing or Runny Nose
- Gum Bleeding
- Hoarseness
- Loss of Taste
- Mononucleosis
- Sore Throat
- Sores
- None

**Genitourinary**

- Blood in Urine
- Bright's Disease
- Burning or painful Urination
- Decrease in force/flow
- Frequent Urination
- Incontinence
- Kidney Stones
- Kidney Trouble
- Night time Urinating
- Prostate Problems
- None

**Hematologic**

- Abnormal Bruising or Bleeding
- Anemia
- Blood Disease
- Excessive Bleeding after tooth extraction
- Phlebitis
- Slow to heal
- None

**Endocrine**

- Become colder than before
- Changes in Hair Growth
- Changes in hat or glove size
- Fatigue Sweating/Night Sweats
- Fever/Chills
- Frequent infections
- Goiter
- Heat/cold intolerance
- Hormone Therapy
- Lymph node Enlargement
- Sleep Problems
- Thyroid Disease
- Weakness/Paralysis
- Weight Change
- None

**Neurological**

- Convulsions/Seizures
- Dizziness
- Fainting Spells
- Gait/Coordination
- Headaches/Migraines
- Paralysis
- Psychiatric Care
- Stroke
- Trauma
- Tremor/Hand Shaking
- None

**Mental Health**

Have you ever been diagnosed or treated for Depression and/or Anxiety?

- Yes
- No

Have you ever been diagnosed or treated for an Eating Disorder (e.g. anorexia/bulimia)?

- Yes
- No

Do you panic when stressed?

- Yes
- No

**Do you have a problem with your appetite when under stress?**

- Yes
- No

**Do you cry frequently?**

- Yes
- No

**Have you ever attempted suicide?**

- Yes
- No

**Have you ever seriously thought about hurting yourself?**

- Yes
- No

**Do you have trouble sleeping?**

- Yes
- No

**Have you ever been to a counselor?**

- Yes
- No

**Have you been diagnosed or treated for Bi-Polar disorder?**

- Yes
- No

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## Men Only

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**Do you usually get up to urinate during the night?**

- Yes
- No

**Any loss of libido or sex drive?**

- Yes
- No

**Any blood in your urine?**

- Yes
- No

**Have you had any kidney, bladder, or prostate infections within the last 12 months?**

- Yes
- No

**Any difficulty with erection or ejaculation?**

- Yes
- No

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## Women Only

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**Heavy periods, irregularity, spotting, pain, or discharge?**

- Yes
- No

**Are you pregnant or breastfeeding?**

- Yes
- No

**Any hot flashes or sweating at night?**

- Yes
- No

**Do you have menstrual tension, bloating, irritability, or other symptoms at or around time of period?**

- Yes
- No

**Recurrent vaginal infections?**

- Yes
- No

**Pain/bleeding with sex?**

- Yes
- No

**Age at onset of menstruation:**

\_\_\_\_\_

**Number of pregnancies:**

\_\_\_\_\_

**Number of live births:**

\_\_\_\_\_

**Number of miscarriages:**

\_\_\_\_\_

**Number of abortions:**

\_\_\_\_\_

**Date of last menstruation:**

\_\_\_\_\_

**Length of cycle:**

\_\_\_\_\_

**Days of flow:**

\_\_\_\_\_

**Birth control method?**

\_\_\_\_\_

**Date of last PAP**

\_\_\_\_\_

**Date of last Mammogram**

\_\_\_\_\_

All Patients

Is there anything that hasn't been covered above that you would like to add or explain?

\_\_\_\_\_

**My signature indicates the above information is correct.**

Signature of Patient (or Guardian/Authorized Representative):

Full Name of above signed (if not patient)

\_\_\_\_\_

Date:

\_\_\_\_\_

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.