



FAMILY MEDICINE

900 NE 10<sup>TH</sup> Street, Oklahoma City, OK 73104  
(405) 271-4311

Patient: _____
MR #: _____ Date: _____
or IDX label

**Review of Systems: Please  Check the items below that you currently have or have experienced recently.**

<b>CONSTITUTIONAL SYMPTOMS</b>	<input type="checkbox"/> Good general health lately <input type="checkbox"/> Recent weight change (gain or loss) <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue or general weakness
<b>EYES / VISION</b>	<input type="checkbox"/> Eye disease or injury <input type="checkbox"/> Wear glasses or contact lenses <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Glaucoma
<b>EARS NOSE MOUTH &amp; THROAT</b>	<input type="checkbox"/> Hearing loss or ringing in ears <input type="checkbox"/> Earaches or drainage <input type="checkbox"/> Chronic sinus problems or rhinitis <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Bad breath or bad taste in mouth <input type="checkbox"/> Sore throat, hoarseness, or voice change <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Swollen glands in neck
<b>CARDIOVASCULAR SYSTEM</b>	<input type="checkbox"/> Heart trouble <input type="checkbox"/> Angina pectoris (chest pain, discomfort, or tightness) <input type="checkbox"/> Palpitations (irregular or forceful heart beats) <input type="checkbox"/> Shortness of breath with walking or lying flat <input type="checkbox"/> Swelling of feet, ankles, or hands
<b>RESPIRATORY SYSTEM</b>	<input type="checkbox"/> Chronic or frequent coughing <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Coughing up mucous
<b>GASTROINTESTINAL SYSTEM</b>	<input type="checkbox"/> Loss of appetite <input type="checkbox"/> Change in bowel movements <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Painful bowel movements or constipation <input type="checkbox"/> Rectal bleeding or blood in stool <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Peptic ulcer (stomach or duodenal) <input type="checkbox"/> Frequent heart burn
<b>MUSCULOSKELETAL SYSTEM</b>	<input type="checkbox"/> Joint pain, stiffness, or swelling <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Muscle pain or cramps <input type="checkbox"/> Back or neck pain <input type="checkbox"/> Cold extremities (hands or feet) <input type="checkbox"/> Difficulty walking
<b>PSYCHIATRIC HEALTH</b>	<input type="checkbox"/> Memory loss or confusion <input type="checkbox"/> Nervousness or anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Difficulty concentrating

<p><b>NEUROLOGICAL SYSTEM</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent or recurring headaches</li> <li><input type="checkbox"/> Light-headed or dizzy</li> <li><input type="checkbox"/> Convulsions or seizures</li> <li><input type="checkbox"/> Numbness or tingling sensations</li> <li><input type="checkbox"/> Tremors or shaking</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Head injury</li> <li><input type="checkbox"/> Poor balance</li> </ul>
<p><b>GENITOURINARY SYSTEM</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Burning or painful urination</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Change in force of strain when urinating</li> <li><input type="checkbox"/> Incontinence or dribbling</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Sexual difficulties</li> <li><input type="checkbox"/> Genital infections or sexually transmitted disease (STD)</li> <li><input type="checkbox"/> Male – testicle pain or swelling</li> <li><input type="checkbox"/> Female – pain with periods</li> <li><input type="checkbox"/> Female – irregular periods</li> <li><input type="checkbox"/> Female – vaginal discharge</li> <li>Female – number of pregnancies _____</li> <li>Female – number of miscarriages _____</li> <li>Female – date of last Pap smear _____</li> </ul>
<p><b>INTEGUMENTARY SYSTEM</b> (skin, hair, nails) <b>&amp;</b> <b>BREAST HEALTH</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Skin rash or itching</li> <li><input type="checkbox"/> Changes in skin color</li> <li><input type="checkbox"/> Boils or blisters</li> <li><input type="checkbox"/> Skin lesions or moles</li> <li><input type="checkbox"/> Hair loss or other scalp problems</li> <li><input type="checkbox"/> Changes in nail growth or condition</li> <li><input type="checkbox"/> Breast pain</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Breast discharge</li> </ul>
<p><b>ENDOCRINE SYSTEM</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Glandular or hormone problem</li> <li><input type="checkbox"/> Thyroid disease</li> <li><input type="checkbox"/> Diabetes (<input type="checkbox"/> insulin or <input type="checkbox"/> non-insulin) check one</li> <li><input type="checkbox"/> Excessive thirst or urination</li> <li><input type="checkbox"/> Heat or cold intolerance</li> <li><input type="checkbox"/> Skin becoming more dry</li> <li><input type="checkbox"/> Change in hat or glove size</li> </ul>
<p><b>HEMATOLOGIC &amp; LYMPHATIC SYSTEMS</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Slow to heal after cuts</li> <li><input type="checkbox"/> Bleeding or bruising tendency</li> <li><input type="checkbox"/> Anemia (low red blood cell levels)</li> <li><input type="checkbox"/> Phlebitis (inflammation of veins) in legs or arms</li> <li><input type="checkbox"/> Varicose (enlarged or twisted) veins in legs</li> <li><input type="checkbox"/> Past blood transfusions</li> <li><input type="checkbox"/> Enlarged glands</li> </ul>
<p><b>ALLERGIES</b></p> <p>Do you have a history of skin or other adverse (bad) reactions to:</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Penicillin or other antibiotics</li> <li><input type="checkbox"/> Morphine, Demerol, or other narcotics</li> <li><input type="checkbox"/> Novocain or other anesthetics</li> <li><input type="checkbox"/> Aspirin or other pain remedies</li> <li><input type="checkbox"/> Tetanus antitoxin or other serums</li> <li><input type="checkbox"/> Iodine, methiolate, or other antiseptics</li> <li><input type="checkbox"/> Other medications: _____</li> <li><input type="checkbox"/> Food allergies: _____</li> <li><input type="checkbox"/> Environmental allergies (animals, trees, pollen, etc.): _____</li> </ul>

Completed by: \_\_\_\_\_  Patient  Parent  Legal Guardian  Clinician