

PLEASE FILL IN THE FOLLOWING

NAME: _____

DATE: _____

WHAT IS YOUR INJURY OR COMPLAINT? _____

REVIEW OF SYSTEMS

SYSTEM Signs & Symptoms	REPLY		SYSTEM Signs & Symptoms	REPLY
CONSTITUTIONAL e.g. Fever, weight loss, malaise	YES NO		MUSCULOSKELETAL e.g. Fracture, sprains, pain, stiffness	YES NO
EYES e.g. Blurring, double vision, glasses	YES NO		SKIN/BREAST e.g. Rashes, lesions, scars, masses	YES NO
EAR, NOSE, THROAT e.g. Deafness, sinusitis, vertigo	YES NO		NEUROLOGICAL e.g. Seizures, balance, memory, stroke	YES NO
CARDIOVASCULAR e.g. Chest pain, palpitations, high blood pressure	YES NO		PSYCHIATRIC e.g. Depression, sleep disturbance, hallucination	YES NO
RESPIRATORY e.g. Short of breath, cough, asthma	YES NO		ENDOCRINE e.g. Increased urination, growth or hair changes, obesity	YES NO
GASTROINTESTINAL e.g. Appetite, abdominal pain, constipation, weight change	YES NO		HEMATOLOGIC/LYMPHATIC e.g. Bleeding tendency, anemia, lymph node pain or enlargmnt	YES NO
GENITOURINARY e.g. Hesitancy, incontinence, pregnancies, menstrual problems	YES NO		ALLERGIC/IMMUNOLOGIC e.g. Allergies, dermatitis, eczema	YES NO

ANY CURRENT or PAST MEDICAL HISTORY/PROBLEMS (PLEASE LIST)? _____

ANY PREVIOUS SURGERIES (PLEASE LIST)? _____

DO YOU TAKE ANY MEDICATIONS (PLEASE LIST)? _____

Are you ALLERGIC to any MEDICATIONS (PLEASE LIST)? _____

ANY FAMILY HISTORY OF MEDICAL PROBLEMS (PLEASE LIST)? _____

SOCIAL HISTORY: What is your profession? _____

Smoking? YES NO

HEIGHT _____ WEIGHT _____

I certify that the information I have provided is correct to the best of my knowledge.

PATIENT SIGNATURE: _____

PHYSICIAN COMMENTS: _____

PHYSICIAN SIGNATURE: _____