PRATT HEALTHCARE

Date: _____

REVIEW OF SYSTEMS:
(Circle each symptom, Yes or No)

CONSTITUTIONAL
Yes No weight loss
Yes No fever
Yes No Fatigue
Yes No weakness

EAR, NOSE, MOUTH, THROAT
Yes No hearing loss
Yes No ear pain/ringing
Yes No mouth ulcers/sores
Yes No teeth decay or dentures
Yes No nose bleeds

EYES
Yes No Glaucoma
Yes No vision loss

LUNGS
Yes No shortness of breath
Yes No asthma/wheezing/cough

GENITOURINARY
Yes No Are you pregnant?
Yes No frequent urinary infections
Yes No blood in urine
Yes No burning with urination
Yes No history of kidney stones
Other: _____

SKIN
Yes No dermatitis/rash

ALLERGIC
Yes No medication

HEMATOLOGIC/LYMPHATIC
Yes No enlarged nodes/glands
Yes No anemia
Yes No bleeding problems

FAMILY HISTORY
Yes No Cancer Type _____
Yes No Colon Polyps

ABDOMINAL
Yes No difficulty swallowing
Yes No heartburn/reflux
Yes No nausea/vomiting
Yes No hiatal hernia
Yes No indigestion
Yes No bloating/belching
Yes No abdominal pain
Yes No peptic ulcer
Yes No gallstones/gallbladder disease
Yes No hepatitis/liver disease
Yes No Crohn's or colitis
Yes No gastrointestinal bleeding
Yes No hemorrhoids
Yes No constipation
Yes No diarrhea/loose stools
Yes No change in bowel habits
Yes No irritable bowel syndrome

HEART
Yes No chest pain
Yes No pacemaker
Yes No history of heart attack
Yes No mitral valve prolapse/murmur
Yes No artificial heart valve
Yes No hypertension
Other: _____

NEUROLOGICAL
Yes No seizure disorder
Yes No chronic headaches
Yes No history of stroke
Other: _____

PSYCHIATRIC
Yes No depression/anxiety
Yes No past evaluation or treatment
Other: _____

ENDOCRINE
Yes No thyroid disease
Yes No diabetes

IMMUNOLOGIC
Yes No HIV/AIDS
Other: _____

Patients Signature: _____

DOB: _____ Primary Care Physician: _____