PRATT HEALTHCARE

Review of Systems- Please circle Yes or no Name: _____ DOB: _____

CONSTITUTIONAL			**URINARY**		
Fever	Yes	No	Hematuria (blood in urine)	Yes	No
Night Sweats	Yes	No	Burning with urination	Yes	No
Weight Gain	Yes	No	**MUSCULOSKELETAL**		
Weight Loss	Yes	No	Joint Pain or Back Pain	Yes	No
Exercise Intolerance	Yes	No	**SKIN**		
EYES			Yellowing of skin	Yes	No
Dry eyes	Yes	No	Rashes	Yes	No
Eye Irritation	Yes	No	**NEUROLOGICAL**		
Vision Changes	Yes	No	Fainting or Loss of Consciousness	Yes	No
EARS/NOSE			Weakness	Yes	No
Difficulty Hearing	Yes	No	Numbness	Yes	No
Ear Pain	Yes	No	Seizures	Yes	No
Nosebleeds	Yes	No	Dizziness	Yes	No
Sinus Problems	Yes	No	Headaches/Migraines	Yes	No
MOUTH/THROAT			**PSYCHIATRIC**		
Sore throat	Yes	No	Depression/Anxiety	Yes	No
Bleeding Gums	Yes	No	Sleep Problems	Yes	No
Snoring	Yes	No	Feeling safe in relationship	Yes	No
Dry Mouth	Yes	No	Alcohol use ____drinks a day or____ drinks per week	Yes	No
Mouth ulcers	Yes	No	**ENDOCRINE**		
Teeth problems	Yes	No	Fatigue	Yes	No
CARDIOVASCULAR			Increased thirst	Yes	No
Chest Pain	Yes	No	Hair Loss	Yes	No
Arm pain with exertion	Yes	No	Increased hair growth	Yes	No
Short of breath when walking	Yes	No	Cold Intolerance	Yes	No
Short of breath when lying down	Yes	No	**HEMATOLOGIC**		
Palpitations	Yes	No	Swollen glands	Yes	No
heart Murmur	Yes	No	Easy bruising	Yes	No
Have you seen a cardiologist	Yes	No	Excessive bleeding	Yes	No
RESPIRATORY			**ALLERGY/IMMUNOLOGIC**		
Cough	Yes	No	Runny nose	Yes	No
Wheeze	Yes	No	**PREGNANT NOW**	Yes	No
Shortness of breath	Yes	No	**PLANNING PREGNANCY**	Yes	No
Coughing up blood	Yes	No	Frequent Sneezing	Yes	No
GI			**FAMILY HISTORY**		
Abdominal pain	Yes	No	Colon Cancer	Yes	No
Vomiting or Nausea	Yes	No	Who?		
Poor appetite	Yes	No	Colon Polyps	Yes	No
Diarrhea	Yes	No	Who?		
Constipation	Yes	No	Esophageal Cancer	Yes	No
Heartburn/Reflux	Yes	No	Who?		
Rectal Bleeding	Yes	No	Stomach Cancer	Yes	No
Problems swallowing	Yes	No	Who?		
Change in Bowel Habits	Yes	No	Other Cancers in Family?	Yes	No

Primary Care Physician: _____ Signature: _____ Date: _____