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Sterling, VA 20164

Present Active Symptoms

NAME:

REVIEW OF SYSTEMS
Please check if you have/had problems related to the areas indicated.

	YES	NO
1. **CONSTITUTIONAL**		
Weight change	❑	❑
Fevers	❑	❑
Sweats	❑	❑
Fatigue	❑	❑
2. **EYES**		
Glaucoma	❑	❑
Cataracts	❑	❑
Vision surgery	❑	❑
3. **EARS, NOSE, THROAT**		
Loss of hearing	❑	❑
Dizziness	❑	❑
Nose bleeding	❑	❑
Gum bleeding	❑	❑
4. **RESPIRATORY**		
Chronic cough	❑	❑
Bronchitis	❑	❑
Shortness of breath	❑	❑
Asthma	❑	❑
Pneumonia	❑	❑
5. **CARDIOVASCULAR**		
Heart attack	❑	❑
Chest pain/angina	❑	❑
Heart murmur	❑	❑
Anemia	❑	❑
Transfusions	❑	❑
Phlebitis or blood clots	❑	❑
Rheumatic fever	❑	❑
6. **GASTROINTESTINAL**		
Reflux	❑	❑
Hepatitis A	❑	❑
Blood in stools	❑	❑
Diarrhea/constipation	❑	❑
Hernia/repair	❑	❑
Gall bladder disease	❑	❑

	YES	NO
7. **ENDOCRINE SYSTEM**		
Diabetes	❑	❑
Thyroid problem	❑	❑
Hormone treatment	❑	❑
Anabolic steroids	❑	❑
8. **BREAST/GENITAL**		
Menopause	❑	❑
Masses	❑	❑
Genital infections	❑	❑
9. **URINARY SYSTEM**		
Urinary tract/bladder infections	❑	❑
Kidney stones	❑	❑
Incontinence	❑	❑
Trouble urinating	❑	❑
Prostate problems	❑	❑
10. **SKIN**		
Cancers	❑	❑
Rashes	❑	❑
11. **NEUROLOGIC**		
Stroke	❑	❑
Seizures	❑	❑
Head injury	❑	❑
Nerve damage	❑	❑
12. **PSYCHIATRIC**		
Depression	❑	❑
Anxiety	❑	❑
13. **MUSCULOSKELETAL**		
Osteoarthritis	❑	❑
Rheumatoid arthritis	❑	❑
Gout	❑	❑

OTHER______________________________
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The information provided in this form is true and complete to the best of my knowledge.

Patient signature______________________________

Updated (date)______________ ______________ ______________
______________ ______________ ______________

*Form reviewed by physician:*______________
*Date:*______________