Name_____ Date of Birth ____/_____/_____ Date _____/ _____/_____

Last Flu Vaccine (month/year) _____/_____ Pneumonia Vaccine? Yes No

REVIEW OF SYSTEMS *(Circle current symptoms or check No Problems*)

Overall Health ___ No problems

Fever Chills Sweats Fatigue Unexplained weight loss / weight gain Failure to thrive (child)

Allergy/Immunology ____No problems

Recurrent infections Weight loss Seasonal allergies Food allergies Animal allergies Sting reactions

Ears, Nose, Throat ___No problems

Sneezing Runny nose Nose congestion Postnasal drip Itchy nose/throat Nosebleeds Face pain

Sinus infections Snoring Ear infections Ear popping Muffled hearing Strep throat Hoarseness

Eyes ___ No problems

Itching Redness Watery Dry/gritty Swelling of lids Rashes of lids

Lungs ____No problems

Dry cough Cough with mucus Wheezing Chest tightness Chest pain Smoke exposure

Heart ___No problems

High blood pressure Irregular heart beat Rapid beat Slow beat Swollen ankles Chest pain Murmur

Gastrointestinal ___No problems

Heartburn Stomach pains Nausea Vomiting Diarrhea Constipation IBS Difficulty swallowing

Blood/Lymph System ___No problems

Bruising Bleeding Anemia Low platelets Swollen glands History of mononucleosis

Endocrine ___ No problems

Diabetes Low blood sugar Thyroid disorder Heat/Cold intolerance Excessive Thirst / Hunger/Urination

Muscles, Bone, Joints ____No problems

Joint pain Joint swelling Muscle pain Osteoarthritis Rheumatoid arthritis Autoimmune disorder

Skin ___No problems

Eczema Hives Rash Itching Dry skin Blisters Poison ivy/oak Metal allergy Swollen lips/eyelids

Neurologic ___No problems

Headaches Migraine Dizziness Fainting Numbness Weakness Tingling

Psychiatric ___ No problems

Depression Anxiety ADD ADHD Insomnia Bipolar Memory changes

COMMENTS ON ANY OF THE ABOVE _____

_____

M.D. / R.N. INITIALS _____