GRAYSON DIGESTIVE DISEASE CONSULTANTS
REVIEW OF SYSTEMS FORM

- CONSTITUTIONAL SYMPTOMS
  - Good general health lately…… No Yes
  - Recent weight change…….. No Yes
  - Fever……. No Yes
  - Fatigue…….. No Yes
  - Headache…….. No Yes

- EYES
  - Eye disease or injury…… No Yes
  - Wear glasses/contact lenses……. No Yes
  - Blurred or double vision…….. No Yes
  - Glaucoma……. No Yes

- EARS/NOSE/MOUTH/THROAT
  - Hearing loss or ringing…… No Yes
  - Earaches or drainage…… No Yes
  - Chronic sinus problem or sinusitis…….. No Yes
  - Nose bleeds……. No Yes
  - Mouth sores……. No Yes
  - Bleeding gums……. No Yes
  - Bad breath or bad taste…… No Yes
  - Sore throat or voice change…… No Yes
  - Swollen glands in neck…….. No Yes

- CARDIOVASCULAR
  - Heart trouble……. No Yes
  - Chest pain or angina pectoris…… No Yes
  - Palpitation……. No Yes
  - Shortness of breath when walking/lying flat. No Yes
  - Swelling of feet, ankles, or hands……. No Yes

- RESPIRATORY
  - Chronic or frequent cough…… No Yes
  - Spitting up blood…….. No Yes
  - Shortness of breath…… No Yes
  - Asthma or wheezing……. No Yes

- GASTROINTESTINAL
  - Loss of appetite……. No Yes
  - Change in bowel habits……. No Yes
  - Nausea or vomiting……... No Yes
  - Frequent diarrhea…….. No Yes
  - Painful bowel movements……. No Yes
  - Rectal bleeding or blood in stool…….. No Yes
  - Abdominal pain or heartburn…… No Yes
  - Peptic ulcer (stomach or duodenal)…….. No Yes

- GENITOURINARY
  - Frequent urination……. No Yes
  - Burning or painful urination…… No Yes
  - Blood in urine…… No Yes
  - Change in force of stream when urinating… No Yes
  - Incontinence or dribbling…….. No Yes
  - Kidney stones……No Yes
  - Sexual difficulty……No Yes
  - Male-testicle pain…….. No Yes
  - Female-pain with periods…….. No Yes
  - Female-irregular periods……No Yes
  - Female-vaginal discharge…….. No Yes
  - Female - # pregnancies_____ # miscarriages _____
  - Female – date of last pap smear_____

- MUSCULOSKELETAL
  - Joint pain…… No Yes
  - Joint stiffness…….. No Yes
  - Weakness of muscles or joints……... No Yes
  - Muscle pain or cramps…… No Yes
  - Back pain…… No Yes
  - Cold extremities……. No Yes
  - Difficulty walking…….. No Yes

- INTEGUMENTARY (skin, breast)
  - Rash or itching……. No Yes
  - Change in skin color…… No Yes
  - Change in hair or nails……. No Yes
  - Varicose veins…….. No Yes
  - Breast pain…… No Yes
  - Breast lump…….. No Yes
  - Breast discharge…… No Yes

- NEUROLOGICAL
  - Frequent or recurring headaches……No Yes
  - Light headed or dizzy…… No Yes
  - Convulsions or seizures……. No Yes
  - Numbness or tingling sensations……... No Yes
  - Tremors……..No Yes
  - Paralysis……No Yes
  - Stroke……No Yes
  - Head injury…… No Yes

- PSYCHIATRIC
  - Memory loss or confusion……. No Yes
  - Nervousness…….. No Yes
  - Depression……. No Yes
  - Insomnia…… No Yes

- ENDOCRINE
  - Glandular or hormone problems…… No Yes
  - Thyroid disease……. No Yes
  - Diabetes……. No Yes
  - Excessive thirst or urination…….. No Yes
  - Heat or cold intolerance……No Yes
  - Skin becoming dryer……..No Yes
  - Change in hat or glove size……No Yes

- HEMATOLOGIC/LYMPHATIC
  - Slow to heal after cuts……No Yes
  - Bleeding or bruising tendency……... No Yes
  - Anemia……...No Yes
  - Phlebitis……. No Yes
  - Past transfusions…… No Yes
  - Enlarged glands……. No Yes

- ALLERGIC/IMMUNOLOGIC
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics……...No Yes
    - Morphine, Demerol or other narcotics….No Yes
    - Novocaine or other anesthetics……No Yes
    - Aspirin or other pain remedies……No Yes
    - Tetanus antitoxin or other serums……No Yes
    - Iodine, merthiolate or other antiseptic….No Yes
    - Other drugs/medications_____
  - Known food allergies_____