La Loma Internal Medicine and Pediatrics
Comprehensive Review of Systems

Instructions: Answer yes if the following problems are **FREQUENT** or **BOTHERSOME**. Explain all yes answers at the end of the last page.

GENERAL:

When was your last physical?	Date:	
Have you had recent UNEXPLAINED change of weight 10+ pounds?	Yes	No
Are you having any fevers?	Yes	No
Do you have excessive fatigue?	Yes	No
Do you have night sweats?	Yes	No
Do you have Hot Flashes?	Yes	No

EARS, EYES, NOSE, THROAT:

Do you have Nasal Congestion?	Yes	No
Do you have frequent runny nose?	Yes	No
Do you have a sore throat?	Yes	No
Have you noticed a change in your vision other than needing new glasses?	Yes	No
Are you having any hearing problems?	Yes	No
Do you have sinus issues?	Yes	No
When was your last eye exam?	Date:	

PULMONARY/LUNGS:

Are you unusually short of breath? If yes, AT REST or WITH ACTIVITY	Yes	No
Do you cough up sputum or mucus most days?	Yes	No
Do you cough up blood?	Yes	No
Have you had a cough for longer than two to three months?	Yes	No
Do you have pain with coughing?	Yes	No
Do you have pain with breathing?	Yes	No

CARDIOVASCULAR/HEART:

Do you get chest pains?	Yes	No
Do you get palpitations often?	Yes	No
Do your legs swell?	Yes	No
Do you have trouble breathing while lying flat?	Yes	No
Do you awaken at night gasping for air?	Yes	No
Do your legs cramp WHILE exercising or walking?	Yes	No
When did you last have your cholesterol checked?	Date:	
Was your cholesterol elevated?	Yes	No

Patient Name: _____

DOB: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER, GALLBLADDER:

Do you have pain in your stomach or abdomen often?	Yes	No
Do you have frequent nausea?	Yes	No
Do you have frequent vomiting?	Yes	No
Do you have diarrhea?	Yes	No
Do you have bright red blood in your stools?	Yes	No
Do you have black tar-like stools?	Yes	No
Are you constipated?	Yes	No
Do you have difficulty swallowing?	Yes	No
Have you had a Colonoscopy or Flexible Sigmoidoscopy of your intestines?	Yes	No
*If you have, when? Date: Were there any polyps?	Benign?	

GENITOURINARY/GENITALS, KIDNEY, BLADDER, URINATION:

Do you have any burning or discomfort with urination?	Yes	No
Do you have any blood in the urine or is the urine dark (tea color)?	Yes	No
Do you urinate more frequently than normal?	Yes	No
Do you have difficulty starting a stream of urine or a weak stream?	Yes	No
Do you urinate more than once or twice per night?	Yes	No
Do you have problems with incontinence (Uncontrolled loss of urine)?	Yes	No
Do you have dribbling?	Yes	No
Do you have sores/lesions on your genitals?	Yes	No

HEMATOLOGIC (BLOOD):

Do you have problems with bleeding or a history of hemophilia? (Circle one)	Yes	No
Have you recently been told you are anemic?	Yes	No

ENDOCRINE (GLANDS) :

Do you have problems with excessive thirst?	Yes	No
Do you feel hotter or colder than those around you? (Circle which one or both)	Yes	No

MUSCULOSKELETAL:

Do you have any joint pain when exercising?	Yes	No
Do your joints swell or get red? (Circle which one or both)	Yes	No

NEUROPSYCHIATRIC (NERVES, BRAIN, MENTAL ILLNESS) :

Do you have problems with insomnia?	Yes	No
Have you ever suffered from depression?	Yes	No
Do you have frequent numbness of your extremities?	Yes	No
Do you have frequent weakness in your legs?	Yes	No

Patient Name: _____

OB/GYN AND BREAST (WOMEN ONLY):

When was your last menstrual period?	Date:		
Are they regular? (Days between Cycles?)		Yes	No
Number of pregnancies and/or deliveries			
Are you postmenopausal?		Yes	No
Are you having bothersome Hot Flashes?		Yes	No
Do you have problems with heavy vaginal bleeding or excessive menstrual pain?		Yes	No
Do you have vaginal discharge that is abnormal?		Yes	No
When was your last pap smear?	Date:		
Have you had a hysterectomy? If yes, was it complete or partial? (Circle one)		Yes	No
Have you had an abnormal Pap Smear?		Yes	No
If yes, When? Have your paps been normal since?		Yes	No
When was your last mammogram?	Date:		
Have you had an abnormal Mammogram? If yes, when?		Yes	No
Have your mammograms been normal since?		Yes	No
Have you had a Bone Density Scan? If yes, when?		Yes	No
Was it abnormal?		Yes	No
Do you take calcium?		Yes	No
Do you do regular self-breast examinations?		Yes	No
Do you use contraceptives? If yes, list the type of Contraceptive:		Yes	No

PROSTATE (MEN ONLY):

When was your last prostate exam?	Date:		
Do you have an enlarged prostate?		Yes	No
When was your last PSA (Prostate Specific Antigen blood test)?	Date:		
Do you have any testicular masses?		Yes	No
Do you have difficulty maintaining an erection?		Yes	No
Do you have penile discharge?		Yes	No

HEALTHCARE MTC:

Do you always wear a seatbelt?		Yes	No
Do you wear sunscreen if you out in the sun for any length of time?		Yes	No
Do you have a smoke detector in your home?		Yes	No
Do you have a living will or designated medical power of attorney?		Yes	No
Do you smoke? (If yes, how packs a day? _____)		Yes	No
Do you drink alcohol at all? (If yes, how many in how long? _____)		Yes	No
When was your last tetanus shot?	Date:		
Have you received the pneumonia vaccines? If so, When?			
When was the last flu shot you have received?			

REVIEWED AND DISCUSSED WITH PATIENT

PHYSICIAN SIGNATURE: _____ DATE:_____

Patient Name: _____