

# Internal Medicine Group

Name \_\_\_\_\_ Acct. # \_\_\_\_\_

DOB \_\_\_\_\_ Physician \_\_\_\_\_

## Review of Systems

Do you now or have you had chronic problems related to the following systems? Circle all that apply and explain on the back.

### Constitutional Symptoms

Fever  
Chills  
Unexplained weight gain or loss  
Excessive fatigue

### Eyes

Blurred or double vision  
Pain in eyes  
Vision loss  
Glaucoma or cataracts  
Date of last eye exam \_\_\_\_\_

### Ears / Nose / Throat / Mouth

Recurrent ear infection  
Chronic sore throat  
Decreased hearing  
Drainage from eyes or ears  
Sores in mouth  
Difficulty swallowing  
Change in voice

### Allergic / Immunologic

Environmental allergies  
Chronic sinus congestion  
Chronic runny nose

### Respiratory

Wheezing  
Frequent cough  
Shortness of breath  
Cough up blood

### Cardiovascular

Palpitations  
Chest pain / pressure  
Decreased activity due to easy fatigue  
Varicose veins  
Pain in calf muscles with walking  
Swelling of ankles

### Gastrointestinal

Chronic diarrhea or constipation  
Abdominal pain  
Nausea / vomiting  
Indigestion / heartburn  
Jaundice  
Hepatitis  
Blood in stool or black stool

Change in bowel movements

Date of last colonoscopy \_\_\_\_\_

### Genitourinary

Blood in urine  
Urine retention  
Urinary frequency  
Painful urination  
Decrease in force of urine stream / dribbling  
Urinary urgency / incontinence  
History of sexually transmitted disease  
FOR MEN  Difficulty getting / retaining an erection  
FOR WOMEN  Vaginal discharge / dryness

### Neurological

Headaches, frequent  
Tremors  
Dizzy spells  
Numbness / tingling

### Endocrine / Metabolic

Excessive thirst  
Too hot / cold  
Tired / sluggish  
Date of last cholesterol test \_\_\_\_\_

### Integumentary

Skin rash  
Boils  
Persistent itch  
New or change in moles

### Musculoskeletal

Muscle pain or weakness  
Joint pain / swelling / redness  
Joint stiffness  
Back / neck pain

### Hematologic / Lymphatic

Persistent swollen glands  
Blood clotting problems  
Anemia  
Blood transfusion  
Date of last tetanus vaccine \_\_\_\_\_  
Date of last flu vaccine \_\_\_\_\_  
Date of last pneumococcal vaccine \_\_\_\_\_

