Name: _____ *¿Habla español?* *Si* *No*

EAC Main Street - Review of Systems

Do you currently, or have you had, a problem with:

Constitutional:	***Circle One***
Fever	Yes No
Weight Loss	Yes No
Excessive Fatigue	Yes No
Eyes:	
Wear glasses	Yes No
Infections	Yes No
Injuries	Yes No
Glaucoma	Yes No
Cataracts	Yes No
Ear, Nose, Throat & Mouth	
Wear hearing aid(s)	Yes No
Hearing loss	Yes No
Ear pain	Yes No
Ear infections	Yes No
Ringing in ears	Yes No
If yes, circle one: Left Right Both	
Nose bleeds	Yes No
Nasal congestion	Yes No
Nasal drainage	Yes No
Inability to smell	Yes No
Sinus problems	Yes No
Balance disturbance (vertigo, spinning, etc.)	Yes No
Cardiovascular	
Chest pain or angina	Yes No
High blood pressure	Yes No
Irregular pulse	Yes No
Heart murmur	Yes No
High cholesterol	Yes No
Swelling in hands or feet	Yes No
Leg pain while walking	Yes No
Respiratory	
Asthma	Yes No
Emphysema	Yes No -
Shortness of breath	Yes No
Pneumonia	Yes No
Lung cancer	Yes No
Bloody sputum	Yes No
Gastrointestinal	
Nausea	Yes No
Vomiting	Yes No
Blood in your vomit	Yes No
Liver disease	Yes No
Jaundice	Yes No
Abdominal pain	Yes No
Change in bowel habits	Yes No
Ulcers or Gastritis	Yes No
Colon cancer	Yes No
Endocrine	
Diabetes	Yes No
Thyroid disease	Yes No
Excessive thirst/urination	Yes No

Genitourinary	***Circle One***
Urinary tract infections	Yes No
Painful urination	Yes No
Blood in your urine	Yes No
Difficult starting/stopping stream	Yes No
Incontinence	Yes No
Kidney stones	Yes No
Prostate cancer (male)	Yes No
Uterine or cervical cancer (female)	Yes No
Musculoskeletal	
Broken bones	Yes No
Arm or leg weakness	Yes No
Arm or leg pain	Yes No
Joint pain or swelling	Yes No
Arthritis	Yes No
Integumentary	
Skin disease	Yes No
Skin cancer	Yes No
Breast pain, tenderness (female)	Yes No
Nipple discharge (female)	Yes No
Neurological	
Fainting spells or "black outs"	Yes No
Seizures	Yes No
Problems with memory	Yes No
Disorientation	Yes No
Difficulty with speech	Yes No
Inability to concentrate	Yes No
Double or blurred vision	Yes No
Weakness in arms and/or legs	Yes No
Loss of sensation	Yes No
Difficulty with balance	Yes No
Psychiatric	
Anxiety	Yes No
Depression	Yes No
Other psychiatric disorder and/or treatment: _____	
_____	
_____	
Hematologic/Lymphatic	
Anemia	Yes No
Hemophilia	Yes No
Bleeding tendencies	Yes No
Blood transfusion	Yes No
Persistent swollen glands or lymph nodes	Yes No
Allergic/Immunologic	
Food allergies	Yes No
Inhalant (nasal) allergies	Yes No
Autoimmune disease (lupus, rheumatoid arthritis, etc.)	Yes No

Last updated: 04/09/2014