Name_____ Date_____

COMPREHENSIVE REVIEW OF MEDICAL HISTORY: REVIEW OF SYSTEMS

Referring Physician: _____ AGE _____ OTPP

Explanation/Detail

Constitutional ☐ Normal ☐ Abnormal
- Bad health recently? No Yes _____
- Recent weight loss? No Yes _____
- Recent weight gain? No Yes _____
- Fatigue? No Yes _____

Ears, nose, throat, mouth ☐ Normal ☐ Abnormal
- Hearing loss? No Yes _____
- Sinus problems? No Yes _____
- Dry throat or mouth? No Yes _____
- Other symptoms? No Yes _____

Heart and blood vessels ☐ Normal ☐ Abnormal
- Palpitations? No Yes _____
- Irregular heartbeat? No Yes _____
  - Do you have a pacemaker? No Yes _____
- Shortness of breath? No Yes _____
  - on exertion or walking? No Yes _____
  - while lying down? No Yes _____
- Swelling - feet, ankles? No Yes _____
- High blood pressure? No Yes _____
- Unusually low blood pressure? No Yes _____
- Chest pain or angina? No Yes _____
- Myocardial infarction (heart attack)? No Yes _____
- hyperlipidemia (high blood cholesterol or lipids)? No Yes _____
- arteriosclerosis (hardening of arteries)? No Yes _____
  - of heart? No Yes _____
  - of carotid arteries? No Yes _____
- Other cardiovascular disease? No Yes _____

Lungs and breathing ☐ Normal ☐ Abnormal
- Wheezing, or asthma? No Yes _____
- Shortness of breath? No Yes _____
- Chronic cough or bronchitis? No Yes _____
- Chronic Obstructive Pulmonary Disease or Emphysema? No Yes _____
- Other lung disease? No Yes _____

Gastrointestinal disease ☐ Normal ☐ Abnormal
- Painful bowel movements or constipation? No Yes _____
- Other Stomach or intestinal disease? No Yes _____

Genitourinary disease ☐ Normal ☐ Abnormal
- Kidney stones or blood in urine? No Yes _____
- Venereal disease? No Yes _____
- Prostate disease? No Yes _____
- Unusual obstetrical events? No Yes _____
- Gynecological disease? No Yes _____
- Other GU disease? No Yes _____

Bones, joints, muscles ☐ Normal ☐ Abnormal
- Pain? No Yes _____
- Weakness? No Yes _____
- Cold extremities? No Yes _____
- Arthritis? No Yes _____
  - rheumatoid type? No Yes _____
- Other disease? No Yes _____

Skin or breast ☐ Normal ☐ Abnormal
- Rash? No Yes _____
- Skin cancer? No Yes _____
- Breast cancer? No Yes _____
- Other disease? No Yes _____

Neurological ☐ Normal ☐ Abnormal
- Head injury? No Yes _____
- Headache? No Yes _____
  - migraine? No Yes _____
  - non-migraine HA? No Yes _____
- Paralysis or stroke? No Yes _____
- Other? No Yes _____

Mental ☐ Normal ☐ Abnormal
- Memory loss? No Yes _____
- Insomnia? No Yes _____
- Depression? No Yes _____
- Nervousness? No Yes _____

Glandular or Endocrine disease ☐ Normal ☐ Abnormal
- Thyroid problem? No Yes _____
- Diabetes? No Yes _____
- Other?

Blood & lymphatic system ☐ Normal ☐ Abnormal
- Bruising, bleeding? No Yes _____
- Slow to heal after cuts? No Yes _____
- Anemia? No Yes _____
- Past blood transfusions? No Yes _____

Allergic and Immune systems ☐ Normal ☐ Abnormal
- Hay fever? No Yes _____
- Food allergy? No Yes _____
- Skin or any adverse reaction to medications? No Yes _____
  - Penicillin or other antibiotics? No Yes _____
  - Sulfa drugs? No Yes _____
  - Other medication reaction? No Yes _____

Family History and Social History:

Diabetes Y N Glaucoma Y N Cataracts Y N

Other Diseases Tobacco use Y N Alcohol Y N

Ocular Medications:

Systemic Medications:

Operations:

Systemic Diagnosis:

Date_____ M.D.

Date Revised & Updated_____ M.D.