ETOWAH GASTROENTEROLOGY ASSOCIATES, PC

PATIENT'S NAME: ____ Date of Birth:_______________

REVIEW OF SYSTEMS (circle or underline)

CONSTITUTIONAL/GENERAL			ALLERGY/IMMUNOLOGY			ENDOCRINOLOGY		
Fever	yes	no	oral ulcerations	yes	no	excessive sweating	yes	no
Chills	yes	no	hives	yes	no	thermal sensitivity	yes	no
Fatigue	yes	no	blistering of skin	yes	no	excessive thirst	yes	no
Sleep difficult	yes	no	rash	yes	no	heat intolerance	yes	no
Weight loss	yes	no	itching	yes	no	change of appetite	yes	no
RESPIRATORY			**CARDIOVASCULAR**			**HEMATOLOGY**		
Chest pain	yes	no	palpitations	yes	no	easy brushing	yes	no
Cough	yes	no	chest pain at rest	yes	no	anemia	yes	no
Short of breath	yes	no	cyanosis	yes	no	prolonged bleeding	yes	no
Sputum	yes	no	claudication	yes	no	swollen glands/nodes	yes	no
Hemoptysis	yes	no	leg swelling	yes	no	blood transfusion	yes	no
Wheezing	yes	no	irregular heartbeats	yes	no			
GENITOURINARY			**MUSCULOSKELETAL**			**PERIPHERAL VASCULAR**		
Blood in urine	yes	no	painful joints	yes	no	blanching of skin	yes	no
Frequent urine	yes	no	swollen joints	yes	no	painful extremities	yes	no
Difficulty urine	yes	no	joint stiffness	yes	no	absent pulses in hand	yes	no
Painful urine	yes	no	back pain	yes	no	absent pulses in leg	yes	no
DERMATOLOGY/SKIN			**NEUROLOGY**			**PYSCHIATRIC**		
Rashes	yes	no	seizure	yes	no	eating disorders	yes	no
Photo sensitive	yes	no	tingling/numbness	yes	no	anxiety	yes	no
Itching	yes	no	transient blindness	yes	no	sleeping disorder	yes	no

OB/GYN HISTORY menstrual abnormality yes no are you pregnant currently yes no

Last menstrual period date:_________________

SIGNATURE: ____