

Centers for Gastroenterology  
Patient Review of Systems

Please fill out your personal information and mark any condition with which you have had significant problems in the past six months.

Patient Name _____		<i>(For nurses use only)</i>	Blood Pressure _____
Date of Birth _____	Age _____	Pharmacy _____	Pulse _____
Today's Date _____			Weight _____ HT _____

PCP: \_\_\_\_\_ Were you referred ? Y N If Yes, by which physician ? \_\_\_\_\_

**Reason for Visit**

	NO	YES	Comments		NO	YES	Comments
<b>Constitutional</b>							
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chills	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____				

<b>HEENT</b>							
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Yellow eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Cardiovascular</b>							
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Pulmonary</b>							
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Excessive snoring	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	TB exposure/positive test	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Gastrointestinal</b>							
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gas/Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bloating/Distention	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Irregular Bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____	Black Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Endocrine</b>							
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Generalized Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Yellowing of skin	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Neurologic</b>							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Focal Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lightheaded/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Genitourinary</b>							
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flank Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heavy menses (female)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____				

<b>Dermatology/Skin</b>							
Severe Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Bone/Joint</b>							
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Hematology</b>							
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Enlarged/painful Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Psychiatric</b>							
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stress/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____				