Review of Systems

Name:	Date:
Date of Birth:	MR #:
Primary Care Physician:	Daytime Phone #:
Health History: Please indicate if you have any of the following.	

Constitutional	**Y**	**N**
Fever		
Chills		
Headache		
Recent weight change CIRCLE ONE: Less than 20 lbs. More than 20 lbs.		
Other		

Eyes/Nose/Throat	**Y**	**N**
Glaucoma		
Glasses		
Sinus Probems		
Other		

Cardiovascular	**Y**	**N**
Chest Pain		
Varicose Veins		
High Blood Pressure		
Other		

Respiratory	**Y**	**N**
Wheezing/Asthma		
COPD		
Shortness of Breath		
Sleep Apnea		
Other		

Endocrine	**Y**	**N**
Diabetes		
Thyroid Disorder		
Other		

Musculoskeletal	**Y**	**N**
Joint Pain		
Neck Pain		
Back Pain		
Other		

Gastrointestinal	**Y**	**N**
Abdominal pain		
Constipation		
Diarrhea		
Nausea/Vomiting		
Indigestion/Heartburn		
Other		

Hematology	**Y**	**N**
Bleed		
Bruise		
Aspirin Last 2 Weeks		
Other		

Neurologic	**Y**	**N**
Tremors		
Dizzy Spells		
Numbness/Tingling		
Other		

Genitourinary	**Y**	**N**
Urinary Frequency		
Urinary Retention		
Painful Urination		
Blood in Urine		
Other		

Psychologic	**Y**	**N**
Anxiety		
Depression		
Other		

Patient signature: ______________________ **Date:** ____________ **Time:** ________

Reviewed by: ______________________ **Date:** ____________ **Time:** ________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Urology Partners

Review of Systems

802422 R 09/12/2013

Name / MR # / Label