

Illinois Gastroenterology, LTD
a member of Premier Medical Group, LLC

REVIEW OF SYSTEMS

CONSTITUTIONAL

Unexplained weight loss/gain Yes No
 Fever Yes No
 Fatigue Yes No

EYES

Blurred vision Yes No
 Glaucoma Yes No

EARS/NOSE/MOUTH/THROAT

Hearing loss Yes No
 **Do you use hearing aids?* Yes No
 Mouth sores Yes No

CARDIOVASCULAR

Chest pain (recently) Yes No
 Shortness of breath (recently) Yes No
 Ankle swelling Yes No
 High blood pressure Yes No
 Abnormal heart rhythm Yes No
 Heart attack Yes No
 Heart stents Yes No

**How many stents?* # _____

**Date(s) of stent placement?* _____

Open heart surgery Yes No
 Congestive heart surgery Yes No

Cardiac testing in the last 6 months? Yes No

**Date of test?* _____

**Location of test?* _____

**Ordering physician?* _____

GASTROINTESTINAL

Poor appetite Yes No
 Difficulty swallowing Yes No
 Heartburn Yes No
 Nausea or vomiting Yes No
 Belching Yes No
 Bloating Yes No
 Regurgitation Yes No
 Constipation Yes No
 Diarrhea Yes No
 Abdominal pain Yes No
 Recent change in bowel habits Yes No
 Rectal bleeding Yes No
 Black, tarry stools Yes No
 Cirrhosis of liver Yes No
 Hepatitis C Yes No
 Fatty liver Yes No

NEUROLOGICAL

Headaches Yes No
 Seizures Yes No
 **If yes, date of last seizure?* _____
 Strokes Yes No
 Numbness Yes No
 MS Yes No

PSYCHIATRIC

Memory loss or confusion Yes No
 Depression Yes No
 Anxiety Yes No
 Bipolar Yes No
 Schizophrenia Yes No
 Dementia Yes No
 ADHD Yes No

REVIEW OF SYSTEMS (cont.)

RESPIRATORY

Chronic cough Yes No
Coughing up blood Yes No
Wheezing Yes No
Asthma Yes No
Emphysema Yes No
Bronchitis Yes No
COPD Yes No
Oxygen Yes No

**How many liters?* _____

**When do you use oxygen?* AM PM

Sleep Apnea Yes No

**Do you use a machine?* Yes No

GENTITOURINARY

Burning with urination Yes No
Blood in urine Yes No
Normal kidney function Yes No

**If not, what stage failure?* _____

Dialysis Yes No

**If yes, what days?* M T W Th F

MUSCULOSKELETAL

Joint pain Yes No
Neck pain Yes No
Back pain Yes No
Muscle pain Yes No

SKIN

Rash Yes No
Itching Yes No
MRSA (currently) Yes No
Shingles (currently/open sore) Yes No

Please list any other medical conditions below:

ENDOCRINE

Heat or cold intolerance Yes No
Excessive thirst or urination Yes No
Thyroid disease Yes No
Diabetic Yes No
Menstrual cycles in last 12 months Yes No

HEMATOLOGICAL

Bleeding or bruising tendency Yes No
Anemia Yes No
Past transfusion Yes No
Do you take blood thinners? Yes No
Bleeding disorders? Yes No

ANESTHESIA

Have you or any blood relative had problems with Anesthesia? Yes No

**If yes, please explain below.*

IMPLANTS/MOBILITY

Any medical implanted devices? Yes No

**If yes, please list below.*

Do you use a wheelchair? Yes No

**If yes, can you transfer to*

a bed or chair alone? Yes No

Do you sign your own legal papers Yes No

**If no, who signs?*

Name

Phone #

Patient Name

Date of Birth

Date