# 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 |



(continued on reverse)

# 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 funtion | ☐ 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 |
| Menstraul 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