SOUTHDALE ALLERGY & ASTHMA CLINIC
Review of Systems

Name: _____ **D.O.B.**_____ **Date:**_____

MEDICAL HISTORY:(List Diagnosed Medical Problems)

FAMILY HISTORY: (Relationship)
Heart Disease
Stroke
Asthma
Diabetes
High Blood Pressure
Cancer (specify)
Other:

PAST SURGERIES:
Reason: Date:

Tobacco History:
Have you ever smoked regularly? YES NO
Do you smoke now? YES NO
Quantity: _____ packs/day
Duration: _____ years
Do you chew tobacco? YES NO

Unusual / Complicated Anesthesia: YES NO

Immunizations:
Flu Shot YES NO
Date: _____
Pneumonia Shot YES NO
Date: _____

Social History:
Do you live alone? YES NO
Do you consume alcohol regularly? YES NO
If yes, how much do you consume daily?

Do you take aspirin or arthritic meds? YES NO
Do you take blood thinners? YES NO
Do you need antibiotics priory to surgery? YES NO

Female Patients:
Are you pregnant? YES NO
Are you nursing? YES NO

Infectious Disease:
Hepatitis YES NO
Infectious Mononucleosis YES NO
Other:

Patient Signature & Date:

x _____

Doctor Signature & Date:

x _____

Subsequent Visits:
Sign & Date: _____
Sign & Date: _____
Sign & Date: _____
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Name: _____ **D.O.B.**_____ **Date:**_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE PROBLEMS WITH:
(PLEASE CIRCLE YES OR NO FOR EACH ITEM)

Constitutional

Fever	YES	NO
Chills	YES	NO
Night sweats	YES	NO
Fatigue	YES	NO
Malaise (Feeling Poorly)	YES	NO
Recent weight loss	YES	NO
Recent weight gain	YES	NO

Hematologic/Lymphatic

Anemia	YES	NO
Abnormal blood count	YES	NO
Bleeding tendencies	YES	NO
Prior transfusion	YES	NO
Transfusion reaction	YES	NO
Easy bruising	YES	NO

Cardiovascular

High blood pressure	YES	NO
Cardiac surgery	YES	NO
Heart murmur	YES	NO
Abnormal pulse/Rhythm	YES	NO
Severe chest pain	YES	NO
Cold hands or feet	YES	NO

Gastrointestinal (Digestive)

Ulcer	YES	NO
Abdominal pain	YES	NO
Change in stool habits	YES	NO
Nausea/Vomiting	YES	NO
Yellow jaundice	YES	NO
Hiatal hernia	YES	NO
Inguinal hernia	YES	NO
Bleeding	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid disorder	YES	NO
Excessive thirst	YES	NO
Flushing of skin	YES	NO

Integumentary (Skin)

Skin turns red when scratched	YES	NO
Skin lesions	YES	NO
Skin rash	YES	NO
Itching	YES	NO
Psoriasis	YES	NO
Change in a mole	YES	NO

Genitourinary

Pelvic pain	YES	NO
Painful urination	YES	NO
Blood in urine	YES	NO
Kidney disease	YES	NO

Ears / Nose / Throat

Hearing problems	YES	NO
Difficulty swallowing	YES	NO
Hoarseness	YES	NO
Sinusitis	YES	NO
Excessive nose bleeds	YES	NO

Eye

Vision problems	YES	NO
Glaucoma	YES	NO
Cataract	YES	NO

Respiratory (Lung)

Asthma	YES	NO
Emphysema	YES	NO
Pneumonia	YES	NO
Bronchitis	YES	NO
Tuberculosis	YES	NO
Daily cough	YES	NO
Productive cough	YES	NO
Chest tightness	YES	NO
Shortness of breath	YES	NO
Sleep apnea	YES	NO

Psychiatric

Depression	YES	NO
Emotional illnesses	YES	NO
Anxiety	YES	NO
Stress	YES	NO

Neurological

Seizures/convulsions	YES	NO
Unconsciousness	YES	NO
Stroke/paralysis	YES	NO
Frequent headaches	YES	NO

Musculoskeletal

Abnormal muscular weaknesses	YES	NO
Joint Pain	YES	NO
Back Pain	YES	NO
Neck Pain	YES	NO
Joint Swelling	YES	NO

Allergic/Immunologic

Autoimmune disorders	YES	NO
Immunodeficiency	YES	NO
Drug allergies (please list below)	YES	NO

_____
_____
_____
_____

Patient Signature & Date:

x _____

Doctor Signature & Date:

x _____

Subsequent Visits:

Sign & Date: _____
Sign & Date: _____
Sign & Date: _____
Sign & Date: _____
Sign & Date: _____
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