



SOUTHDALE ALLERGY & ASTHMA CLINIC
Review of Systems

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

MEDICAL HISTORY:(List Diagnosed Medical Problems)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST SURGERIES:

Reason: _____ Date: _____

FAMILY HISTORY: (Relationship)

- Heart Disease _____
- Stroke _____
- Asthma _____
- Diabetes _____
- High Blood Pressure _____
- Cancer (Specify) _____
- Other _____

DRUG ALLERGIES: YES NO

SOCIAL HISTORY

- Do you live alone? YES NO
- Do you consume alcohol regularly? YES NO
- If yes, how much daily? _____
- Do you take aspirin or arthritic meds? YES NO
- Do you take blood thinners? YES NO
- Do you need antibiotics prior to surgery? YES NO

TOBACCO HISTORY

- Have you ever smoked regularly? YES NO
- Do you smoke now? YES NO
- Quantity: _____ packs/day
- Duration: _____ year/s
- Do you chew tobacco? YES NO
- Do you snore? YES NO

SKIN Do you have problems with rash, hives, cold sores, eczema, changes in skin/hair? YES NO

HAVE YOU HAD OR DO YOU CURRENTLY HAVE PROBLEMS WITH:

Blood Disorders

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

Eye, Ear, Nose & Throat

- Vision problems YES NO
- Glaucoma YES NO
- Hearing problems YES NO
- Difficulty swallowing YES NO
- Hoarseness YES NO
- Sinusitis YES NO

Neuro/Muscular Disease

- Seizures/convulsions YES NO
- Unconsciousness YES NO
- Stroke/paralysis YES NO
- Abnormal muscular weakness YES NO
- Frequent headaches YES NO
- Other _____

Cardiovascular Disease

- High blood pressure YES NO
- Cardiac surgery YES NO
- Abnormal pulse/rhythm YES NO
- Chest pain YES NO
- Heart murmur YES NO

Female Patients

- Are you pregnant YES NO
- Are you nursing YES NO

Infectious Disease

- Hepatitis YES NO
- Other _____

Lung Disease

- 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

Unusual/Complicated Anesthesia

YES NO

Explain: _____

Immunizations

- Flu shot YES NO
- Pneumonia shot YES NO

Digestive Disorder

- 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
- Bleeding YES NO

Psychological

- Depression YES NO
- Emotional illness YES NO
- Anxiety YES NO

Metabolic Problems

- Diabetes YES NO
- Thyroid disorder YES NO

Patient Signature & Date:

x _____

Doctor Signature & Date:

x _____

I have reviewed systems with patient.

Subsequent Visits:

Sign & Date _____

Sign & Date _____

Sign & Date _____

Sign & Date _____