Review of Body Systems
Please answer all of the following:

Your Name:_____ Date:_____

1. Constitutional
   - Recent Weight Loss? ..... yes no
   - Recent fevers/chills? ..... yes no
   - Recent or chronic lack of energy? ..... yes no
2. Ears, Nose & Throat
   - Ringing in ears? ..... yes no
   - Significant loss of hearing? ..... yes no
   - Loss of sense of smell? ..... yes no
   - Sore or irritated throat? ..... yes no
3. Cardiovascular
   - Chest palpitations? ..... yes no
   - Severe Chest Pains? ..... yes no
   - Shortness of breath during strenuous physical activity? ..... yes no
   - **Do you have high blood pressure?** ..... yes no
4. Respiratory
   - Shortness of breath at rest? ..... yes no
   - Chronic or recent cough? ..... yes no
5. Gastrointestinal
   - Blood in stools? ..... yes no
   - Severe stomach pains? ..... yes no
6. Musculoskeletal
   - Chronic or recent muscle pain? ..... yes no
   - Chronic or recent join pain? ..... yes no
   - Chronic or recent swelling of arms or legs? yes no
7. Neurological
   - Short term memory loss? ..... yes no
   - Seizure activity? ..... yes no
   - Chronic or recent severe headaches? ..... yes no
8. Hematology/lymphatic/oncologic
   - **Do you have known cancer?**_____ yes no
   - Do you bruise easily? ..... yes no
   - New lumps under your jaw or around your neck (big lymph nodes)? ..... yes no
9. Endocrine
   - **Do you have diabetes?** ..... yes no
   - Do you have to frequently empty your bladder at night? ..... yes no
   - Are you intolerant to cold? ..... yes no
   - Recent onset of tremors? ..... yes no
10. Integument
    - Do you have a known chronic skin disease? yes no
    - Recent onset skin rash? ..... yes no
11. Eye
    - Do you have chronic redness? ..... yes no
    - Are you sensitive to light? ..... yes no
    - Do your eyes hurt? ..... yes no

Medications (include aspirin, birth control pills and insulin if appropriate)

Name	Dose	Frequency

PAST & CURRENT ILLNESSES

PREVIOUS SURGERIES

Family Health History
(NOT YOU; Your family)

Glaucoma?	yes	no
Diabetes?	yes	no
High blood pressure?	yes	no
High cholesterol?	yes	no
Heart Disease?	yes	no
Overactive Thyroid?	yes	no
Retinal detachment?	yes	no
Macular degeneration?	yes	no
"Crossed eyes"?	yes	no
Unexplained poor vision?	yes	no
Problems with anesthesia?	yes	no

Deceased "D"	Good Health "GH"	Bad Health "BH"

Indicate cause of death

Mother: _____

Father: _____

Sibling: _____

Sibling: _____

Sibling: _____

Personal Habits/Social History

I regularly smoke: no yes: ☐ cigarettes ☐ cigars ☐ pipes

How many packs per day? ____
For how many years? ____

Do you regularly drink alcohol? no yes; ☐ 2 to 5 oz./day ☐ >6 oz./day
Do you regularly drink beer? no yes; ☐ 1 to 3 bottles/day
☐ 4 or more bottles/day

Are you married? no yes
Are you currently employed? no yes retired

Allergies to medications? yes no; list below:

Do you have problems with anesthesia? yes no

_____ _____ DATE_____

LEE BOTTEM, DO