

HUGH N. HAZENFIELD, M.D., F.A.C.S.

REVIEW OF SYSTEMS

Do you (or the patient) currently have or have experienced any of these problems?

Table with 2 columns of symptoms and 2 columns of YES/NO checkboxes. Symptoms include: Recent weight change, Fever, Fatigue, New skin lesions, rashes, Change in skin, Trouble seeing, Cough, Wheezing, Chest pain, Shortness of breath, Trouble lying flat, Palpitations of the heart, Leg swelling, Trouble swallowing, Heartburn, Vomiting, Change in color of stools, Change in size of stools, Change in frequency of stools, Decreased hearing, Recent colds, Sinus problems, Tooth pain / disease, Gum pain / disease, Swollen glands, Abdominal pain, Joint pain, Gout, Low back pain, Stiffness, Cramps in leg with walking, Local weakness, Change in memory, Trouble sleeping, Heat or cold intolerance, Excessive thirst, Easy bruising, Free bleeding, Loss of sensation hands or feet.

Please explain anything marked "Yes":

Four horizontal lines for writing an explanation.

Have there been any other changes in your health (including surgery) since your last visit?

Three horizontal lines for writing a response.

Your Primary Care Physician's Name: _____

What medications are you taking at present?

Table with 6 columns: Name, Dosage, Frequency, Name, Dosage, Frequency. Includes four rows of horizontal lines for data entry.

If you smoke, how much per day: _____ Alcohol consumption: _____

Do you have any new allergies or reactions to drugs? Yes No

If yes, describe: _____

(Women only) Are you pregnant? Yes No If yes, approximate date of conception: ___/___/___

(For Office Use Only)

PATIENT NAME: _____ DATE: _____