

# WACO GASTROENTEROLOGY ASSOCIATES

Review of Systems for the Last 12 Months

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

<p><b>Constitutional:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Weight Change  <input type="checkbox"/> Yes <input type="checkbox"/> No Fever  <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue</p> <p><b>Eyes:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred Vision  <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma</p> <p><b>Ears/Nose/Mouth/Throat:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Loss  <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in ears  <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth Sores</p> <p><b>Cardiovascular:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain  <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Defibrillator  <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Disease  <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath  <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of Ankles  <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take blood thinners?  <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take Aspirin, Naprosin or Advil?</p> <p><b>Respiratory:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Cough  <input type="checkbox"/> Yes <input type="checkbox"/> No Spitting Up Blood  <input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing</p> <p><b>Genitourinary:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Burning with Urination  <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in Urine</p> <p><b>Musculoskeletal:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain or Swelling  <input type="checkbox"/> Yes <input type="checkbox"/> No Back Pain  <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle Pain  <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement (such as knee or hip)</p> <p><b>Skin:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Rash  <input type="checkbox"/> Yes <input type="checkbox"/> No Itching</p> <p><b>Hematological:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Tendency  <input type="checkbox"/> Yes <input type="checkbox"/> No Bruising Tendency  <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia  <input type="checkbox"/> Yes <input type="checkbox"/> No Past Transfusion</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <b>Are you Pregnant?</b></p> <p><b>Have you ever had:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer  <input type="checkbox"/> Yes <input type="checkbox"/> No Colon Polyps  <input type="checkbox"/> Yes <input type="checkbox"/> No Gastric Polyps  <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers  <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease  <input type="checkbox"/> Yes <input type="checkbox"/> No Pancreatitis  <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease</p> <p>Please Explain: _____          _____          _____          _____          _____          _____</p>	<p><b>Gastrointestinal:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Poor Appetite  <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Swallowing  <input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn  <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea or Vomiting  <input type="checkbox"/> Yes <input type="checkbox"/> No Bloating  <input type="checkbox"/> Yes <input type="checkbox"/> No Belching  <input type="checkbox"/> Yes <input type="checkbox"/> No Regurgitation  <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation  <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea  <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain  <input type="checkbox"/> Yes <input type="checkbox"/> No Change in Bowel Habits  <input type="checkbox"/> Yes <input type="checkbox"/> No Rectal Bleeding  <input type="checkbox"/> Yes <input type="checkbox"/> No Black, Tarry Stool</p> <p><b>Neurological:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches  <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures  <input type="checkbox"/> Yes <input type="checkbox"/> No Strokes  <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness</p> <p><b>Previous Procedures:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Colonoscopy  <input type="checkbox"/> Yes <input type="checkbox"/> No EGD                  (If "YES") When? _____ Physician: _____</p> <p><b>Psychiatric:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Memory Loss / Confusion  <input type="checkbox"/> Yes <input type="checkbox"/> No Depression</p> <p><b>Endocrine:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Heat or Cold Intolerance  <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Thirst / Urination  <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetic</p> <p><b>Social Habits:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever smoked?  <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently smoke?                  _____ If YES, Number of Packs per day?  <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used alcohol?  <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently drink?                  _____ If YES, How Much?</p> <p><b>Family History:</b>                  Has your mother, father, brother or sister ever had?                  (M=mother) (F=father) (S=sister) (B=brother)  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Cancer  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Colon Polyps  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Gastric Polyps  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Ulcers  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Liver Disease  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Pancreatitis  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B High Blood Pressure  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Allergies  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Psychiatric Problems  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Diabetes  <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B Other Diseases</p> <p>Please Explain: _____          _____          _____          _____</p>
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