SGC Specialty Gastro Center

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Patient Name:____________________ Date of Birth:____________________

REVIEW OF SYSTEMS

CHECK ALL THAT APPLY AT THE PRESENT TIME:

☐ NONE

GENERAL
- ☐ CHILLS
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
  AMOUNT? _______
- ☐ WEIGHT LOSS
  AMOUNT? _______
- ☐ FEELING TIRED OR POORLY

EYES
- ☐ WORSENING VISION
- ☐ BLURRED VISION
- ☐ VISION DISTORTION
- ☐ EYE PAIN

OTOLARYRIGEAL SYMPTOMS
- ☐ EARACHE
- ☐ NASAL DISCHARGE
- ☐ MOUTH SORES
- ☐ BLEEDING GUMS
- ☐ HOARSENESS
- ☐ THROAT PAIN
- ☐ FACIAL PAIN
- ☐ SINUS PAIN

CARDIOVASCULAR
- ☐ CHEST PAIN/DISCOMFORT
- ☐ FAST HEART RATE
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS
- ☐ OTHER – PLEASE LIST: ____________________
- ☐ OTHER – PLEASE LIST: ____________________

RESPIRATORY
- ☐ CHRONIC COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH

GASTROINTESTINAL
- ☐ ABDOMINAL SWELLING
- ☐ ABDOMINAL PAIN
- ☐ BELCHING
- ☐ BLACK STOOLS
- ☐ RED BLOOD IN BOWEL MOVEMENT
- ☐ CHANGE IN BOWEL MOVEMENT FREQUENCY
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ DIFFICULTY SWALLOWING
- ☐ FATTY FOOD INTOLERANCE
- ☐ FULL AFTER EATING SMALL MEAL
- ☐ BLOATING/GAS
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ YELLOW SKIN OR EYES
- ☐ GALLBLADDER DISEASE
- ☐ NAUSEA
- ☐ PAIN WITH SWALLOWING
- ☐ DECREASE IN APPETITE
- ☐ RECTAL BLEEDING
- ☐ RECTAL PAIN
- ☐ REGURGITATION OF FOOD
- ☐ INCONTINENCE OF STOOL
- ☐ VOMITING
- ☐ VOMITING BLOOD

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS
- ☐ SWOLLEN JOINTS
- ☐ LOW BACK PAIN
- ☐ MUSCLE PAIN

SKIN SYMPTOMS
- ☐ PRURITIS (ITCHING)
- ☐ SKIN LESIONS
- ☐ RASHES

NEUROLOGIC
- ☐ NUMBNESS OR TINGLING
- ☐ DIZZINESS/LIGHTHEADEDNESS
- ☐ VERTIGO
- ☐ HEADACHES
- ☐ WEAKNESS IN ARMS OR LEGS
- ☐ MEMORY LAPSES OR LOSS

PSYCHIATRIC
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PANIC ATTACKS
- ☐ LOSS OF SLEEP
- ☐ OTHER – PLEASE LIST: ____________________
- ☐ OTHER – PLEASE LIST: ____________________

ENDOCRINE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE URINATION
- ☐ HOT FLASHES

HEMATOLOGIC / LYMPHATIC
- ☐ EASY BRUISING TENDENCY
- ☐ SWOLLEN GLANDS
- ☐ NOSEBLEEDS

URINARY
- ☐ PAIN OF DIFFICULTY WITH URINATION
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ INCONTINENCE OF URINE

GENITOREPRODUCTIVE FEMALE
- ☐ VAGINAL DISCHARGE
- ☐ HEAVY PERIODS

DATE OF LAST PERIOD ____________________

GENITOREPRODUCTIVE MALE
- ☐ DISCHARGE FROM PENIS
- ☐ TESTICULAR PAIN
- ☐ TESTICULAR LUMP

Patient Signature:____________________ Date:____________________

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