

# C. PHILIP O'CARROLL, M.D.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Physician (PCP or GP): \_\_\_\_\_

## REVIEW OF SYSTEMS

(Patient's condition at time of appointment and/or condition being seen for today)

Please place a check next to any symptom or condition that applies to you. Specify details, if necessary, in the "other" space.

<p><b>Constitutional</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Other _____ _____	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Claudication <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations <input type="checkbox"/> Other _____ _____	<p><b>Reproductive-Male</b></p> <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Penile discharge <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Other _____ _____	<p><b>Neurological</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Extremity numbness <input type="checkbox"/> Extremity weakness <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Memory impairment <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Other _____ _____	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Neck pain/Cervicalgia <input type="checkbox"/> Other _____ _____	
<p><b>Head, Eyes, Ears, Nose</b></p> <p style="text-align: center;"><b>Throat</b></p> <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Sinus pressure <input type="checkbox"/> Sore throat <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____ _____	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stool <input type="checkbox"/> Change in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____ _____	<p><b>Reproductive-Female</b></p> <input type="checkbox"/> Abnormal pap <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Dyspareunia <input type="checkbox"/> Hot flashes <input type="checkbox"/> Irregular menses <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____ _____	<p><b>Psychiatric</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Other _____ _____	<p><b>Hematologic/Lymphatic</b></p> <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Other _____ _____	
<p><b>Respiratory</b></p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Cough <input type="checkbox"/> Known TB exposure <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____ _____	<p><b>Genitourinary</b></p> <input type="checkbox"/> Dribbling (Male pts only) <input type="checkbox"/> Dysuria <input type="checkbox"/> Hematuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Slow stream <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention <input type="checkbox"/> Other _____ _____	<p><b>Integumentary</b></p> <input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast lump <input type="checkbox"/> Brittle hair <input type="checkbox"/> Brittle nails <input type="checkbox"/> Hair loss <input type="checkbox"/> Hirsutism <input type="checkbox"/> Hives <input type="checkbox"/> Pruritis <input type="checkbox"/> Mole changes <input type="checkbox"/> Rash <input type="checkbox"/> Skin lesion <input type="checkbox"/> Other _____ _____	<p><b>Metabolic/Endocrine</b></p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Polydipsia <input type="checkbox"/> Polyphagia <input type="checkbox"/> Other _____ _____	<p><b>Immunologic</b></p> <input type="checkbox"/> Contact allergy <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Food allergies <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Other _____ _____	
				<p><b>PAIN SCALE</b></p> <p>Pain Level (1-10, 10 being the worst)</p>	<p><b>Advanced Directive / POA</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Other _____

### FOR EXISTING PATIENTS ON FOLLOW-UP VISITS or RE-EVALUATION APPOINTMENTS

<p><b>TOBACCO USE:</b> Have you ever used tobacco? <input type="checkbox"/> No/Never <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (If Yes, please answer below)</p> <p>Check all that apply:</p> <p><b>Type:</b> <input type="checkbox"/> Cigarette <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing <input type="checkbox"/> Smokeless <input type="checkbox"/> Snuff</p> <p><b>Usage:</b> Daily <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ <input type="checkbox"/> Stick <input type="checkbox"/> Pack</p>	<p><b>ALCOHOL INTAKE</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <p><b>CAFFEINE INTAKE</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____
<p><b>FAMILY HISTORY</b> (Please check all that apply) N/A IF ADOPTED - Pls CIRCLE</p> <input type="checkbox"/> N/A Adopted _____ <input type="checkbox"/> No Change since last seen _____ _____	<p>Relationship/Maternal-Paternal</p> <p><input type="checkbox"/> Migraine  <input type="checkbox"/> Strokes  <input type="checkbox"/> Heart attacks  <input type="checkbox"/> Movement Disorder (Tremor, Parkinson's)  <input type="checkbox"/> Other _____</p>
<p><b>OTHER:</b></p>	<p>Onset Age Ck if Deceased &amp; AgeD</p> <p>_____ <input type="checkbox"/> _____          _____ <input type="checkbox"/> _____          _____ <input type="checkbox"/> _____          _____ <input type="checkbox"/> _____</p>