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.

Constitutional
- ◯ Chills
- ◯ Fatigue
- ◯ Fever
- ◯ Malaise
- ◯ Night sweats
- ◯ Weight gain
- ◯ Weight loss
- ◯ Other_____

Head, Eyes, Ears, Nose Throat
- ◯ Ear discharge
- ◯ Ear pain
- ◯ Eye discharge
- ◯ Eye pain
- ◯ Hearing loss
- ◯ Nasal drainage
- ◯ Sinus pressure
- ◯ Sore throat
- ◯ Visual changes
- ◯ Other_____

Respiratory
- ◯ Chronic cough
- ◯ Cough
- ◯ Known TB exposure
- ◯ Shortness of breath
- ◯ Wheezing
- ◯ Other_____

Cardiovascular
- ◯ Chest pain
- ◯ Claudication
- ◯ Edema
- ◯ Palpitations
- ◯ Other_____

Gastrointestinal
- ◯ Abdominal pain
- ◯ Blood in stool
- ◯ Change in stool
- ◯ Constipation
- ◯ Diarrhea
- ◯ Heartburn
- ◯ Loss of appetite
- ◯ Nausea
- ◯ Vomiting
- ◯ Other_____

Genitourinary
- ◯ Dribbling (Male pts only)
- ◯ Dysuria
- ◯ Hematuria
- ◯ Polyuria
- ◯ Slow stream
- ◯ Urinary frequency
- ◯ Urinary incontinence
- ◯ Urinary retention
- ◯ Other_____

Reproductive-Male
- ◯ Erectile dysfunction
- ◯ Penile discharge
- ◯ Sexual dysfunction
- ◯ Other_____

Reproductive-Female
- ◯ Abnormal pap
- ◯ Dysmenorrhea
- ◯ Dyspareunia
- ◯ Hot flashes
- ◯ Irregular menses
- ◯ Vaginal discharge
- ◯ Other_____

Integumentary
- ◯ Breast discharge
- ◯ Breast lump
- ◯ Brittle hair
- ◯ Brittle nails
- ◯ Hair loss
- ◯ Hirsutism
- ◯ Hives
- ◯ Pruritis
- ◯ Mole changes
- ◯ Rash
- ◯ Skin lesion
- ◯ Other_____

Neurological
- ◯ Dizziness
- ◯ Extremity numbness
- ◯ Extremity weakness
- ◯ Gait disturbance
- ◯ Headache
- ◯ Memory impairment
- ◯ Seizures
- ◯ Tremors
- ◯ Other_____

Psychiatric
- ◯ Anxiety
- ◯ Depression
- ◯ Insomnia
- ◯ Other_____

Metabolic/Endocrine
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Polydipsia
- ◯ Polyphagia
- ◯ Other_____

OTHER

Musculoskeletal
- ◯ Back pain
- ◯ Joint pain
- ◯ Joint swelling
- ◯ Muscle weakness
- ◯ Neck pain
- ◯ Other_____

Hematologic/Lymphatic
- ◯ Easy bleeding
- ◯ Easy bruising
- ◯ Lymphadenopathy
- ◯ Other_____

Immunologic
- ◯ Contact allergy
- ◯ Environmental allergies
- ◯ Food allergies
- ◯ Seasonal allergies
- ◯ Other_____

PAIN SCALE

Pain Level (1-10, 10 being the worst)

Advanced Directive / POA
- ◯ YES
- ◯ NO
- ◯ Other_____

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

TOBACCO USE: Have you ever used tobacco? ◯ No/Never ◯ Yes ◯ Unknown (If Yes, please answer below)

Check all that apply:

Type: ◯ Cigarette ◯ Cigar ◯ Pipe ◯ Chewing ◯ Smokeless ◯ Snuff

Usage: Daily ◯ Yes ◯ No How many? _____ ◯ Stick ◯ Pack

Age started:_____

Age stopped:_____

ALCOHOL INTAKE

◯ Yes ◯ No Type_____

CAFFEINE INTAKE

◯ Yes ◯ No Type_____

FAMILY HISTORY (Please check all that apply) **N/A IF ADOPTED - Pls CIRCLE**

◯ N/A Adopted

◯ No Change since last seen

	Relationship/Maternal-Paternal	Onset Age	Ck if Deceased & AgeD
◯ Migraine			◯
◯ Strokes			◯
◯ Heart attacks			◯
◯ Movement Disorder (Tremor, Parkinson's)			◯
◯ Other _____			◯

OTHER: