

Gregory K. Harmon, M.D

REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

Reason for Visit: _____

Please answer the following by circling “YES” or “NO”

▪ **Constitutional Symptoms**

Fever/Chills **YES** **NO**

▪ **Skin**

Itching or Dryness **YES** **NO**

▪ **Eyes**

Visual Changes **YES** **NO**

▪ **Neurological**

Headache/Dizziness **YES** **NO**

▪ **Respiratory**

Shortness of Breath **YES** **NO**

▪ **Gastrointestinal**

Difficulty Swallowing **YES** **NO**

▪ **Hematologic/Lymphatic**

Any bleeding disorders? **YES** **NO**

▪ **Genitourinary**

Urinate Frequently **YES** **NO**

▪ **Endocrine**

Any hormonal or thyroid problems? **YES** **NO**

▪ **Musculoskeletal**

Joint Pain/Swelling **YES** **NO**

▪ **Ear, Nose, Mouth, Throat**

Hearing Changes **YES** **NO**

▪ **Psychiatric**

Depression **YES** **NO**

▪ **Cardiovascular**

Chest Pains **YES** **NO**

▪ **Do you have a history of:**

Cancer **YES** **NO**

If yes, what type of cancer do you have?

High Blood Pressure **YES** **NO**

Diabetes **YES** **NO**

Thyroid Disease **YES** **NO**

Eye Disease **YES** **NO**

Other: _____

▪ **Do you have a family history of:**

High Blood Pressure **YES** **NO**

Heart Disease **YES** **NO**

Diabetes **YES** **NO**

Eye Disease **YES** **NO**

Other: _____

▪ **Have you had**

Surgery **YES** **NO**

If yes, what type of surgery did you have?

▪ **Do you smoke? YES NO**

▪ **Do you drink? YES NO**

▪ **What medications are you currently taking?** _____

▪ **Do you have any allergies to medications? YES NO**

If yes, which medications are you allergic to?

Patient’s Signature: _____

Reviewed by M.D.: _____ CODE: _____ Date: _____