CLEAR LAKE BRAIN AND SPINE INSTITUTE

REVIEW OF SYSTEM FORM

DATE: _____ NAME: _____ DATE OF BIRTH: _____

TOBACCO USE: YES/NO HOW MUCH? _____/DAY/MONTH HOW LONG? _____ QUIT DATE_____

ALCOHOL USE: YES/NO HOW MUCH PER DAY/WEEK/MONTH? _____

CAFFIENE (COFFEE, TEA, SODAS) PER DAY _____

CURRENT MEDICATIONS: _____

_____

_____

REVIEW OF SYSTEMS – PLEASE WRITE BY EACH LINE "Y" OR "N" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	YES/NO
Weight Loss	_____
Fatigue	_____
Fever	_____
EYES:	YES/NO
Glasses/Contacts	_____
Eye Pain	_____
Double Vision	_____
Cataracts	_____
EAR, NOSE, THROAT:	YES/NO
Difficulty Hearing	_____
Ringing in Ears	_____
Vertigo	_____
Sinus Trouble	_____
Nasal Stiffness	_____
Frequent Sore Throat	_____
CARDIOVASCULAR:	YES/NO
Murmur	_____
Chest Pain	_____
Palpitations	_____
Fainting Spells	_____
Shortness of Breath	_____
Difficulty lying flat	_____
Swelling Ankles	_____

RESPIRATORY:	YES/NO
Cough	_____
Coughing Blood	_____
Wheezing	_____
Chills	_____
GASTROINTESTINAL:	YES/NO
Heartburn/Reflex	_____
Nausea/Vomiting	_____
Constipation	_____
Change in BMs	_____
Diarrhea	_____
Jaundice	_____
Abdominal Pain	_____
Black or Bloody BM	_____
GENITOURINARY:	YES/NO
Burning/Frequency	_____
Blood in Urine	_____
Erectile Dysfunction	_____
Abnormal Discharge	_____
Bladder Leakage	_____
ALLERGIC/IMMUNOLOGIC:	YES/NO
Hives/Eczema	_____
Hay Fever	_____

HEMATOLOGY/LYMPH:	YES/NO
Easy Bruising	_____
Gums Bleed Easily	_____
Enlarged Glands	_____
MUSCULOSKELETAL:	YES/NO
Joint Pain/Swelling	_____
Stiffness	_____
Muscle Pain	_____
Back Pain	_____
SKIN:	YES/NO
Rash/Sores	_____
Lesions	_____
Itching/Burning	_____
NEUROLOGICAL:	YES/NO
Loss of Strength	_____
Numbness	_____
Headaches	_____
Memory Loss	_____
ENDOCRINE:	YES/NO
Loss of hair	_____
Heat/Cold Intolerance	_____
PSYCHIATRIC:	YES/NO
Anxiety/Depression:	_____
Mood Swings	_____
Difficult Sleeping	_____