

Name: _____ DOB: _____

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Review of Systems

Please check if you have any of the following

Fatigue	<input type="checkbox"/>	Nasal Obstruction	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Chills	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>
Rash	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Unable to Control Bowels	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
Headache	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	Tingling	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	Tremor	<input type="checkbox"/>
Blurry Vision	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Unable to Control Bladder	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Backache	<input type="checkbox"/>		

Do you take any prescription or over the counter medications? YES NO

If yes please list:

<u>Medication</u>	<u>Dosage</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any Medications YES NO

If yes please list

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized or had surgery? YES NO

If yes please list:

<u>Date</u>	<u>Reason</u>	<u>Where</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was your last tetanus injection: _____

Do you have Metal in your body? Such as pin, plate, screws foreign body or pacemaker. YES NO

If yes what and where: _____

Are you Claustrophobic?

Have you ever had metal in your eyes? YES NO

If yes, is it still there. YES NO

FEMALES ONLY

Are you pregnant or think you might be pregnant? YES NO

Social History

Do you Smoke? YES NO

If yes _____ cigarettes per day _____ Cigars per day/week _____ Number of years

Do you use other tobacco? YES NO

If yes _____ Snuff _____ Chewing Tobacco _____ Number of years

Do you Drink? YES NO

If yes _____ Beers per week _____ Glasses of wine per week _____ Mixed drinks per week

Name: _____ DOB: _____

Please list your hobbies: _____

Do you exercise _____ YES NO

Describe: _____

Are you working? _____ YES NO Part time _____ Full time _____

Job Title: _____ How long have you done this type of work? _____

How long for your current company: _____

Do you have more than one job? _____ YES NO

Use the symbols below and draw on the diagrams where your symptoms are.

ACHE
>>>>

NUMBNESS

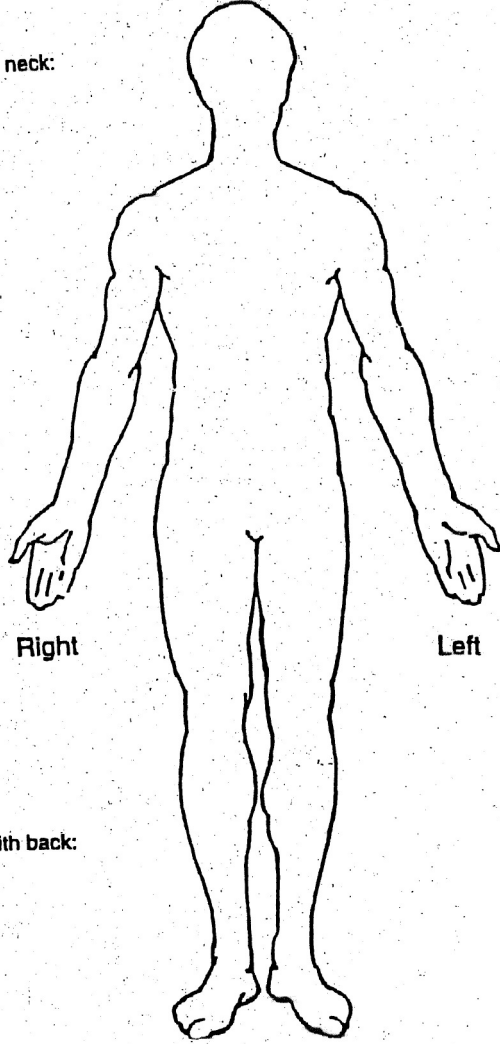
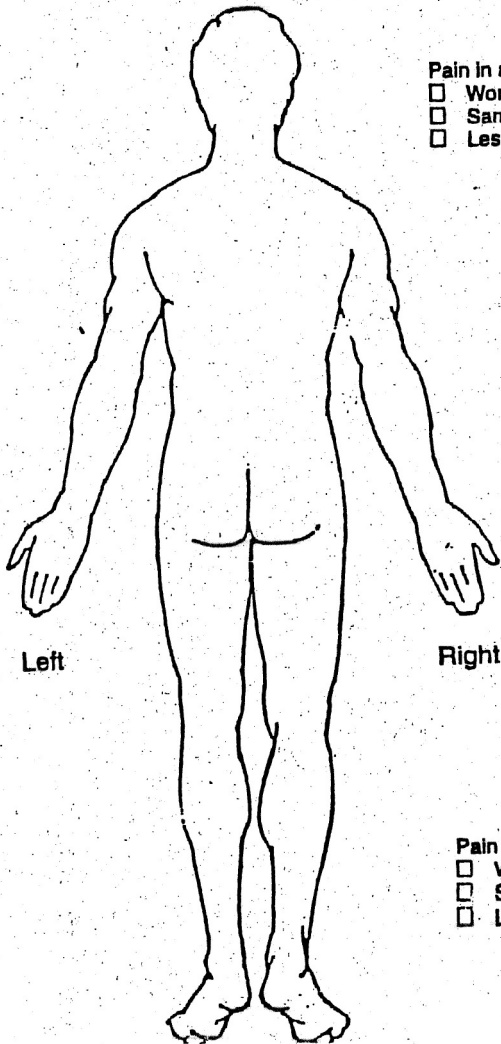
PINS & NEEDLES
0000 0000 0000

BURNING
XXXX XXXX

STABBING
//// //// ////

Back

Front



Pain in arm(s) compared with neck:
 Worse than
 Same as
 Less than

Pain in leg(s) compared with back:
 Worse than
 Same as
 Less than

I hereby declare that, to the best of my knowledge and belief, the information given above is correctly recorded, complete, and true

Patient Signature _____

Date _____