



# SCOTT & WHITE OUTPATIENT HISTORY

MRN:

Name:

Age:

Date of Birth:

## REVIEW OF SYSTEMS

**DATE:**

**REVIEW OF SYSTEMS:** If you have trouble with any of the following **in the last year**, check the problem(s). If you do not have any of the problem selections, check the "No Problem" box.

**GENERAL:**

- |   |                                   |                                     |
|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Unusual weight changes | <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Pain       |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Weakness | <input type="checkbox"/> No Problem |

**SKIN:**

- |                                  |   |                                     |
|----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Rashes  | <input type="checkbox"/> Changes in skin, hair or nails |                                     |
| <input type="checkbox"/> Dryness |   | <input type="checkbox"/> No Problem |

**EYES:**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Pain              | <input type="checkbox"/> Blurring vision |                                     |
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Vision halos    |                                     |
| <input type="checkbox"/> Dryness           | <input type="checkbox"/> Vision flashes  |                                     |
| <input type="checkbox"/> Redness           | <input type="checkbox"/> Eyestrain       | <input type="checkbox"/> No Problem |

**EARS:**

- |                                   |   |                                     |
|-----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Drainage | <input type="checkbox"/> Constant ringing |                                     |
| <input type="checkbox"/> Earache  | <input type="checkbox"/> Hearing loss     | <input type="checkbox"/> No Problem |

**NOSE:**

- |  |                                     |                                     |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Nosebleeds      | <input type="checkbox"/> Discharge  |                                     |
| <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Sinus pain | <input type="checkbox"/> No Problem |

**MOUTH:**

- |  |                                      |                                     |
|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Gum soreness    | <input type="checkbox"/> Tongue pain |                                     |
| <input type="checkbox"/> Teeth condition |                                      | <input type="checkbox"/> No Problem |

**THROAT:**

- |                                     |   |                                     |
|-------------------------------------|---|-------------------------------------|
|                                     | <input type="checkbox"/> Swelling           |                                     |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> No Problem |

**LUNGS:**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing      |                                     |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Phlegm/Sputum |                                     |
| <input type="checkbox"/> Coughing blood      | <input type="checkbox"/> Pleurisy      |                                     |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Asthma        | <input type="checkbox"/> No Problem |

**HEART & CIRCULATION:**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Chest pain, tightness or pressure | <input type="checkbox"/> Ankle swelling      |                                     |
| <input type="checkbox"/> Irregular heart beat              | <input type="checkbox"/> Low blood pressure  |                                     |
| <input type="checkbox"/> Fast or slow heart beat           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> No Problem |



**REVIEW OF SYSTEMS (continued)**

Patient Identification

**URINARY:**

- Frequency or painful urinating
- Pus in urine
- Losing control of urine/wetting self
- Urinating at night
- Blood in urine
- No Problem

**STOMACH, INTESTINES AND COLON:**

- Nausea
- Vomiting
- Vomiting blood
- Change in bowel habits
- Constipation
- Diarrhea
- Food intolerance
- Rectal bleeding
- Indigestion
- Flatus/Passing gas
- No Problem

**MUSCLES, JOINTS & BONES:**

- Joint stiffness or pain
- Backache
- Limitation of joint or muscle movement
- Joint swelling or redness
- Muscle pains or cramps
- Bone pain
- No Problem

**NERVOUS SYSTEM:**

- Fainting
- Seizures/Epilepsy
- Tremors
- Memory loss
- Blackouts
- Paralysis
- Tingling of part of body
- Headaches
- No Problem

**HORMONES:**

- Heat or cold intolerance
- Excessive thirst, hunger or urination
- No Problem

**BLOOD/ALLERGIES:**

- Anemia
- Bleeding gums
- Easy bruising or bleeding
- Hives or welts
- No Problem

**PSYCHOLOGICAL:**

- Depression
- Loss of interest in activities that are normally enjoyed
- Difficulty sleeping
- Difficulty concentrating
- Nervousness
- Alcohol and drug abuse
- No Problem

**GENITALS:**

MEN Only:

- Sores
- Groin swelling
- Penile discharge
- Hernias
- Testicular pain or masses
- Breast lump
- Erection difficulties

WOMEN Only:

- Irregular periods
- Very painful periods
- Bleeding between periods
- Sores
- Vaginal discharge
- Breast lump
- Painful intercourse
- No Problem

DATE                      PATIENT OR RESPONSIBLE PARTY SIGNATURE                      DOCTOR'S SIGNATURE