SOUTHERN INDIANA NEPHROLOGY AND HYPERTENSION, PC

Review of Systems

*Name*____ *Date* __________

As part of your visit, we would like to get an idea of your overall health. Please circle yes or no for each question listed below.

General	**Response**	
1. Have you recently been hospitalized?	Yes	No
If so, where? ____________________ when?______________		
2. Do you have problems with fevers or chills on a regular basis?	Yes	No
3. Have you recenly been on an antibiotic?	Yes	No
4. Do you take any over the counter medicines for pain (NSAIDs like Aleve, ibuprophen, Motrin, etc)?	Yes	No
5. Have you recently had any kind of test where you got dye or contrast?	Yes	No
6. Have you had any weight loss or gain in the last year?	Yes	No
7. Have you had any night sweats?	Yes	No
8. Do you frequently feel weak, tired, or lack energy?	Yes	No

Comments:

Head/Eyes/Nose		
1. Have you had any recent changes in your vision, hearing, or speech?	Yes	No
2. Do you have sinus congestion on a regular basis?	Yes	No
3. Do you get sores in your mouth on a regular basis?	Yes	No

Comments:

Heart		
1. Do you have chest pain?	Yes	No
2. Do you wake up in the night feeling short of breath?	Yes	No
3. Do you sleep on more than 2 pillows or upright in the bed or recliner?	Yes	No

Comments:

Lungs		
1. Do you feel short of breath at rest?	Yes	No
2. Do you feel short of breath with activity?	Yes	No
3. Do you have a cough on a regular basis?	Yes	No

Comments:

Stomach/Bowels		
1. Have you have any bitter tastes in your mouth recently?	Yes	No
2. Do you throw-up on a regular basis?	Yes	No
3. Do you ever see any bright red blood in your stools?	Yes	No
4. Do you ever have dark, tarry stools?	Yes	No
5. Do you have diarrhea on a regular basis?	Yes	No

Comments:

Kidneys	**Response**	
1. Do you ever see any blood in your urine?	Yes	No
2. Do you have pain or burning when you urinate?	Yes	No
3. Do you notice any foaminess to your urine?	Yes	No
4. Have you ever passed any kidney stones?	Yes	No
5. Do you strain to urinate?	Yes	No
6. Do you feel like you have fully emptied your bladder when you urinate?	Yes	No
6. Do you get up in the night to urinate?	Yes	No

Comments:

Skin		
1. Do you get any rashes or sores on a regular basis?	Yes	No
2. Do you have any open areas on your skin now?	Yes	No

Comments:

Muscles/Bones		
1. Do you have any joints that are red, hot, and swollen?	Yes	No
2. Do you have any joints that hurt on a daily basis?	Yes	No

Comments:

Nerves		
1. Do you have any numbness or tingling in your feet or hands?	Yes	No
2. Do you have weakness on one side or the other?	Yes	No
3. Have you had any problems with seizures?	Yes	No

Comments:

Endocrine		
1. Do you feel you are always hot?	Yes	No
2. Do you feel you are always cold?	Yes	No
3. If you have diabetes, is your blood sugar regularly more than 200?	Yes	No
4. Do you have trouble sleeping?	Yes	No
5. Has your energy level changed?	Yes	No

Comments:

Blood/Lymph Nodes		
1. Do you notice easy bruising?	Yes	No
2. Have you had any recent bleeding?	Yes	No
3. Have you noticed any swollen glands recently?	Yes	No

Comments:

Patient Signature___________________________________ Date____________

Physician Signature_________________________________ Date____________