



GASTROENTEROLOGY ASSOCIATES

Consultative Gastroenterology, Hepatology and Gastrointestinal Endoscopy

Name: _____

Date: _____

Review of Systems

Please indicate if you have any of the following symptoms:

Constitutional

Recent weight gain No Yes
 Recent weight loss No Yes
 Fever No Yes
 Fatigue No Yes

Eyes

Blurred vision No Yes
 Glaucoma No Yes

Ears/Nose/Mouth/Throat

Hearing loss No Yes
 Ringing in ears No Yes
 Mouth sores No Yes

Cardiovascular

Chest pain No Yes
 Shortness of breath No Yes
 Swelling of ankles No Yes

Respiratory

Chronic cough No Yes
 Spitting up blood No Yes
 Wheezing No Yes

Genitourinary

Burning with urination No Yes
 Blood in urine No Yes

Musculoskeletal

Joint pain or swelling No Yes
 Back pain No Yes
 Muscle pain No Yes

Skin

Rash No Yes
 Itching No Yes

Gastrointestinal

Poor appetite No Yes
 Difficulty in swallowing No Yes
 Heartburn No Yes
 Nausea or vomiting No Yes
 Bloating No Yes
 Belching No Yes
 Regurgitation No Yes
 Constipation No Yes
 Diarrhea No Yes
 Abdominal Pain No Yes
 Recent change in bowel habits No Yes
 Blood in stools No Yes
 Hepatitis No Yes
 Jaundice No Yes
 Pancreatitis No Yes

Neurological

Headaches No Yes
 Seizures No Yes
 Strokes No Yes

Psychiatric

Memory loss No Yes
 Depression No Yes

Endocrine

Thyroid Problems No Yes
 Diabetes No Yes

Menstrual History

Age of Menarche _____
 Menopause No Yes
 Menstruating No Yes

Hematological

Anemia No Yes
 Past transfusion No Yes

COMMENTS:

GA099

Office use only	
REVIEWED:	
Date: _____	By: _____
Date: _____	By: _____
Date: _____	By: _____
Date: _____	By: _____