



# 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

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REVIEWED:	
Date: _____	By: _____
Date: _____	By: _____
Date: _____	By: _____
Date: _____	By: _____