LAKE SHORE
DERMATOLOGY

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PATIENT NAME (PLEASE PRINT):____

DATE: ____

REVIEW OF SYSTEMS: PLEASE ANSWER REGARDING ANY CURRENT PROBLEMS AND EXPLAIN

Constitutional

Feeling tired or poorly	❑ Yes	❑ No
Fever (as symptom)	❑ Yes	❑ No
Chills (as symptom	❑ Yes	❑ No
Recent weight loss (lbs ________)	❑ Yes	❑ No
Recent weight gain (lbs ________)	❑ Yes	❑ No

Ophthalmology

Blurry vision	❑ Yes	❑ No
Change in vision	❑ Yes	❑ No
Decreased vision	❑ Yes	❑ No
Eye irritation	❑ Yes	❑ No

Ear, Nose, Throat

Nasal congestion	❑ Yes	❑ No
Post-nasal drip	❑ Yes	❑ No
Sore throat	❑ Yes	❑ No
Earache	❑ Yes	❑ No
Ringing of ears	❑ Yes	❑ No
Difficulty swallowing	❑ Yes	❑ No

Respiratory

Cough	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No

Cardiovascular

Palpitations	❑ Yes	❑ No
Chest pain	❑ Yes	❑ No
Leg swelling	❑ Yes	❑ No
Varicose veins	❑ Yes	❑ No

Gastrointestinal

Decreased appetite	❑ Yes	❑ No
Abdominal pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Blood in stool	❑ Yes	❑ No

Urinary

Pain during urination	❑ Yes	❑ No
Increased frequency of urination	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No

Musculoskeletal

Muscle pain	❑ Yes	❑ No
Decrease in muscle strength	❑ Yes	❑ No
Joint pain	❑ Yes	❑ No
Joint stiffness	❑ Yes	❑ No

Neuro

Headaches	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No

Psychiatric

Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No

Endocrine

Excessive thirst	❑ Yes	❑ No
Heat/cold intolerance	❑ Yes	❑ No
Excessive sweating	❑ Yes	❑ No

Heme

Easy bruising	❑ Yes	❑ No
Night sweats	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Swollen glands	❑ Yes	❑ No

Allergic/Immunologic

Hives	❑ Yes	❑ No

Gynecologic (women only)

Pregnant	❑ Yes	❑ No
Trying to conceive	❑ Yes	❑ No
Difficulty conceiving	❑ Yes	❑ No
Irregular periods	❑ Yes	❑ No

Other ______________________________
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PATIENT SIGNATURE: ____

PARENT OR GUARDIAN SIGNATURE: ____

DATE: ______________________________

PHYSICIAN SIGNATURE: ____________________________________ DATE: ____________________