

Kathryn Naus Hester MD

Rheumatology

Review of Systems

As you review the following list, please check any problems which have significantly affected you.

<p>Constitutional</p> <ul style="list-style-type: none"><input type="checkbox"/> Recent weight gain<input type="checkbox"/> Recent weight loss, _____pounds in the past _____ months<input type="checkbox"/> Fever <p>Eyes</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain<input type="checkbox"/> Redness<input type="checkbox"/> Loss of vision<input type="checkbox"/> Double or blurred vision<input type="checkbox"/> Dryness<input type="checkbox"/> Feels like something in eye<input type="checkbox"/> Itching eyes <p>Ears–Nose–Mouth–Throat</p> <ul style="list-style-type: none"><input type="checkbox"/> Loss of hearing<input type="checkbox"/> Nosebleeds<input type="checkbox"/> Sores in mouth<input type="checkbox"/> Hoarseness<input type="checkbox"/> Difficulty in swallowing <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> Irregular heart beat<input type="checkbox"/> Sudden changes in heart beat<input type="checkbox"/> High blood pressure<input type="checkbox"/> Heart murmurs <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Shortness of breath<input type="checkbox"/> Difficulty in breathing at night<input type="checkbox"/> Swollen legs or feet<input type="checkbox"/> Cough<input type="checkbox"/> Coughing of blood<input type="checkbox"/> Wheezing (asthma) <p>Endocrine</p> <ul style="list-style-type: none"><input type="checkbox"/> Excessive thirst <p>Hematologic/Lymphatic</p> <ul style="list-style-type: none"><input type="checkbox"/> Swollen glands<input type="checkbox"/> Tender glands<input type="checkbox"/> Bleeding tendency<input type="checkbox"/> Blood Transfusion in the past, when? _____ <p>Allergic/Immunologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequent sneezing<input type="checkbox"/> Hives	<p>Gastrointestinal</p> <ul style="list-style-type: none"><input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting of blood or coffee ground material<input type="checkbox"/> Persistent diarrhea<input type="checkbox"/> Blood in stools<input type="checkbox"/> Black stools<input type="checkbox"/> Heartburn <p>Genitourinary</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain or burning on urination<input type="checkbox"/> Blood in urine<input type="checkbox"/> Getting up at night to pass urine<input type="checkbox"/> Rash/ulcers on genitals <p><i>For Women Only:</i></p> <p>Age when periods began: _____</p> <p>Periods regular? Yes _____ No _____</p> <p>How many days apart? _____</p> <p>Date of last period? _____</p> <p>Date of last pap? _____</p> <p>Bleeding after menopause? Yes _____ No _____</p> <p>Number of pregnancies? _____</p> <p>Number of miscarriages? _____</p> <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Morning stiffness Lasting how long? _____<input type="checkbox"/> Muscle weakness<input type="checkbox"/> Muscle tenderness<input type="checkbox"/> Joint swelling <p>Integumentary (skin and/or breast)</p> <ul style="list-style-type: none"><input type="checkbox"/> Easy bruising<input type="checkbox"/> Rash<input type="checkbox"/> Sun sensitive (sun allergy)<input type="checkbox"/> Tightness<input type="checkbox"/> Nodules/bumps<input type="checkbox"/> Hair loss<input type="checkbox"/> Color changes of hands or feet in the Cold <p>Neurological System</p> <ul style="list-style-type: none"><input type="checkbox"/> Fainting<input type="checkbox"/> Loss of consciousness <p>Psychiatric</p> <ul style="list-style-type: none"><input type="checkbox"/> Easily losing temper<input type="checkbox"/> Depression<input type="checkbox"/> Agitation
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