SELF-ASSESMENT FORM

St. Joseph Medical Center

Review of Systems: Please indicate any personal history below:

EYE
Eye disease or injury ☐ Yes ☐ No
Wear glasses/contact lenses ☐ Yes ☐ No
Blurred or double vision ☐ Yes ☐ No
Glaucoma/ cataracts ☐ Yes ☐ No

EARS/NOSE/THROAT
Hearing loss or ringing ☐ Yes ☐ No
Earaches or drainage ☐ Yes ☐ No
Chronic sinus problem or rhinitis ☐ Yes ☐ No
Nose bleeds ☐ Yes ☐ No
Mouth sores ☐ Yes ☐ No
Sore throat or voice change ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No

CARDIOVASCULAR
Heart trouble ☐ Yes ☐ No
Chest pain or angina pectoris ☐ Yes ☐ No
Palpitation ☐ Yes ☐ No
Shortness of breath w/ walking ☐ Yes ☐ No
or lying flat ☐ Yes ☐ No

RESPIRATORY
Chronic or frequent coughs ☐ Yes ☐ No
Spitting up blood ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Asthma or wheezing ☐ Yes ☐ No

GASTROINTESTINAL
Loss of appetite ☐ Yes ☐ No
Change in bowel movement ☐ Yes ☐ No
Nausea or vomiting ☐ Yes ☐ No
Frequent diarrhea ☐ Yes ☐ No
Painful bowel movements ☐ Yes ☐ No
or constipation ☐ Yes ☐ No
Rectal bleeding or blood in stool ☐ Yes ☐ No
Abdominal pain ☐ Yes ☐ No
Peptic ulcer (stomach or duodenal) ☐ Yes ☐ No

GENITOURINARY
Frequent urination ☐ Yes ☐ No
Burning or painful urination ☐ Yes ☐ No
Awaken at night to urinate ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Change in force or strain when urination. ☐ Yes ☐ No
Incontinence or dribbling ☐ Yes ☐ No
Sores or discharge ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Sexual difficulty ☐ Yes ☐ No
Male - testicle pain/lumps ☐ Yes ☐ No
Female - pain with periods ☐ Yes ☐ No
Female - irregular periods ☐ Yes ☐ No
Female -vaginal discharge ☐ Yes ☐ No

Female - # of pregnancies_____

Female - # of miscarriages _____

Female - date of last pap smear _____

MUSCULOSKELETAL
Good general health lately ☐ Yes ☐ No
Recent weight change ☐ Yes ☐ No
Decreased appetite ☐ Yes ☐ No
Fever/Night sweats ☐ Yes ☐ No
Fatigue/Weakness ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

INTEGUMENTARY (SKIN, BREAST)
Rash or itching ☐ Yes ☐ No
Change in skin color. ☐ Yes ☐ No
Change in hair or nails ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Breast pain ☐ Yes ☐ No
Breast discharge ☐ Yes ☐ No

NEUROLOGICAL
Frequent or recurring headaches ☐ Yes ☐ No
Lightheaded or dizzy ☐ Yes ☐ No
Convulsions or seizures ☐ Yes ☐ No
Numbness or tingling sensations ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Head injury ☐ Yes ☐ No

PSYCHIATRIC
Memory loss or confusion ☐ Yes ☐ No
Nervousness ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No

ENDOCRINE
Glandular or hormone problem ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No
Diabetes (insulin or non-insulin-circle one) ☐ Yes ☐ No
Excessive thirst or urination ☐ Yes ☐ No
Heat or cold intolerance ☐ Yes ☐ No

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts ☐ Yes ☐ No
Bleeding or bruising tendency ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Phlebitis ☐ Yes ☐ No
Enlarged glands ☐ Yes ☐ No

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ☐ Yes ☐ No
Morphine, Demerol or other narcotics ☐ Yes ☐ No
Novocain or other anesthetics ☐ Yes ☐ No
Aspirin or other pain remedies ☐ Yes ☐ No
Tetanus antitoxin or other serums ☐ Yes ☐ No
Iodine, methiolate or other antiseptic ☐ Yes ☐ No

Other drugs/medications:_____

Known food allergies: _____

Environmental allergies: _____