MountainStar
Wound Care & Hyperbaric Medicine
at Ogden Regional

Review of Systems

Patient Name:_____ DOB:_____ MR#: _____

Date:_____ Sex: M / F Chief Complaint: _____

Primary Physician:_____ Referring Physician: _____

GENERAL		
Any weight gain/loss of > 10# last 6 months? Circle one	Yes	No
Any change in appetite or interest in eating?	Yes	No
Have you ever had cancer? Which type?	Yes	No
Have you ever had prior radiation treatment?	Yes	No

HEAD/NECK		
Do you have headaches > 1 week?	Yes	No
Do you have sinus disease/allergies/hay fever?Circle one	Yes	No
Does your nose stop/run when you do not have a cold? Circle one	Yes	No
Do you have nosebleeds?	Yes	No
Do you have problems with teeth or gums?	Yes	No
Have you had a change in your voice or recent hoarseness?	Yes	No

EARS		
Do you have difficulty hearing?	Yes	No
Do you have buzzing or noise in your ears?	Yes	No
Have you ever had ear surgery?	Yes	No
Have you ever had mastoiditis?	Yes	No

EYES		
Do you wear glasses or contacts?	Yes	No
Have you had any recent vision changes?	Yes	No
Have you had optic neuritis?	Yes	No
Do you see double?	Yes	No

CHEST		
Do you have or have you ever had chest pain?	Yes	No
Do you have or have you ever had shortness of breath?	Yes	No
Do you have or have you ever had wheezing?	Yes	No
Do you have or have you ever had tuberculosis or positive skin test?	Yes	No
Do you have or have you ever had pneumonia?	Yes	No
Do you have or have you ever had asthma or emphysema/COPD? Circle one	Yes	No
Do you have shortness of breath when lying flat?	Yes	No
Do you cough up phlegm on a regular basis?	Yes	No

BLOOD DISORDERS		
Have you ever been anemic?	Yes	No
Have you ever had sickle cell anemia?	Yes	No
Have you ever had spherocytosis?	Yes	No
Have you ever had unusual bleeding?	Yes	No
Have you ever had a personal or family history of clotting?	Yes	No

CARDOVASCULAR		
Do you have irregular heartbeats?	Yes	No
Do you have fast heartbeats?	Yes	No
Do you have shortnes of breath that awakens you?	Yes	No
Do you have chest pain or shortness of breath with exertion?	Yes	No
Have you ever had leaky or bad heart valve?	Yes	No
Have you ever had rheumatic fever?	Yes	No
Have you ever had leg pain that begins when you are walking?	Yes	No

GASTROINTESTINAL - GI		
Have you had a change in appetite or weight?	Yes	No
Have you had nausea?	Yes	No
Have you had a change in size, color, or frequency, or stools? Circle one	Yes	No
Have you had blood in your bowel movement?	Yes	No
Have you had jaundice or liver disease?	Yes	No
Have you had hepatitis?	Yes	No
Have you had any difficulty swallowing?	Yes	No
Have you had recent diarrhea?	Yes	No

BLADDER/KIDNEY - GU		
Do you get up at night to urinate?	Yes	No
Have you had kidney disease?	Yes	No
Have you ever had venereal disease?	Yes	No
Have you ever had kidney stones?	Yes	No
Have you ever had prostate problems?	Yes	No

MUSCULOSKELETAL		
Have you had joint or muscle pain?	Yes	No
Do you have pain, swelling, or redness in your joints? Circle one	Yes	No
Have you ever had osteoporosis?	Yes	No
Have you ever had night cramps?	Yes	No
Have you ever had sprains or fractures?	Yes	No
Are you handicapped in any way?	Yes	No

ENDOCRINE/METABOLIC		
Have you ever had thyroid problems?	Yes	No
Have you ever had frequent urination?	Yes	No
Have you ever had sugar in your urine?	Yes	No
Have you ever had diabetes?	Yes	No
Have you ever had high cholesterol?	Yes	No

LYMPH		
Do you have any enlarged lymph nodes?	Yes	No
Do you have draining or infected lymph nodes?	Yes	No

SKIN

Do you have any skin sores or rashes?	Yes	No
Do you have any itching?	Yes	No
Do you have any bruising or bleeding?	Yes	No
Do you have any drainage from under your skin?	Yes	No
Do you have any moles that have changes?	Yes	No

CENTRAL NERVOUS SYSTEM

Have you ever had a stroke or "mini-stroke"?	Yes	No
Have you ever had paralysis?	Yes	No
Have you ever had unusual muscle movement?	Yes	No
Have you ever had spine injury or pain?	Yes	No
Have you ever had epilepsy or seizures?	Yes	No
Have you ever had a head injury?	Yes	No
Have you ever been knocked unconscious?	Yes	No
Have you ever had trouble walking?	Yes	No
Have you ever had trembling or shaking?	Yes	No
Have you ever had hallucinations?	Yes	No
Have you ever had a nervous breakdown?	Yes	No
Have you ever had depression?	Yes	No
Have you ever used illicit drugs of any kind?	Yes	No

REPRODUCTIVE SYSTEM

When was your last period?	Yes	No
Was your last period unusual?	Yes	No
Do you spot or bleed between periods?	Yes	No
Have you had a miscarriage or abortion?	Yes	No
Are you taking birth control pills?	Yes	No
Do you use birth control?	Yes	No
Have you ever had complications with birth control?	Yes	No
Have you ever had an abnormal PAP test?	Yes	No
Has it been over one year since your last PAP test?	Yes	No

BREASTS

Has it been over one year since your last PAP mammogram?	Yes	No
Have you ever had lumps or pain in your breasts?	Yes	No
Have you ever had any discharge from your breasts?	Yes	No
Has it been over one month since you did a breast self-examination?	Yes	No

NUTRITION

Do you eat as least three meals a day? If no, how many?_____	Yes	No
Do you have a fruit or vegetable at each meal?	Yes	No
Do you eat protein at each meal? (meat, beans, nuts, lentils, soy, protien supplement)	Yes	No
Do you know how many calories you need to consume in a day?	Yes	No
Would you like a meal plan for wound healing?	Yes	No

PAST MEDICAL HISTORY

Medications:

ALLERGIES:

Immunizations:

Surgeries:

Hospitalizations:

Wound Care in the Past:

Do you take or have you taken an of the following medications?					
Cisplatin, Carboplatin, or any platinum containing chemotherapy agents?	Yes ☐	No ☐	Disulfiram (Antabuse) ☐	Yes ☐	No ☐
			Acetazolamide (Diamox) ☐	Yes ☐	No ☐
Doxorubicin (Adriamycin) ☐	Yes ☐	No ☐	Novantrone ☐	Yes ☐	No ☐
Bleomycin ☐	Yes ☐	No ☐			

Are you currently pregnant or trying to conceive?	Yes ☐	No ☐
Do you have a pacemaker? ☐	Yes ☐	No ☐

List all your current and previous occupations:

FAMILY HISTORY					
Seizures ☐	Yes ☐	No ☐	Hypertension (HTN) ☐	Yes ☐	No ☐
Coronary Artery Disease (CAD) ☐	Yes ☐	No ☐	Diabetes Mellitus (DM) ☐	Yes ☐	No ☐
Congestive Heart Failure (CHF) ☐	Yes ☐	No ☐	Cancer ☐	Yes ☐	No ☐
Asthma ☐	Yes ☐	No ☐	Negative ☐	Yes ☐	No ☐
COPD ☐	Yes ☐	No ☐	Adopted ☐	Yes ☐	No ☐
Pneumothorax ☐	Yes ☐	No ☐			

SOCIAL HISTORY					
Cigarettes?	Yes ☐	No ☐	Alocohol?	Yes ☐	No ☐
If "yes"...How many packs per day?			If "yes" How many drinks per day?		
How many years?			Caffeine?	Yes ☐	No ☐
Recreational Drugs?	Yes ☐	No ☐	If "yes" How much per day?		
If "yes"…Which drugs?					
How often?					

Living Conditions			Mobility		
Nursing Home ☐	Yes ☐	No ☐	Unassisted ☐	Yes ☐	No ☐
Assisted Living ☐	Yes ☐	No ☐	With assistance ☐	Yes ☐	No ☐
Lives alone ☐	Yes ☐	No ☐	With cane or crutches ☐	Yes ☐	No ☐
Live with family ☐	Yes ☐	No ☐	Walker ☐	Yes ☐	No ☐
			Transfers only ☐	Yes ☐	No ☐
			Wheelchair ☐	Yes ☐	No ☐
			Other ☐	Yes ☐	No ☐