Raymond M. Thomas, MD, PC
Gastroenterology/Hepatology

Name: _____
Primary Care Dr_____

# REVIEW OF SYSTEMS (To be completed at every visit)

Reason for coming in today_____ How long its been a problem_____

## A) CURRENT SYMPTOMS: Indicate if you presently have any of the following symptoms:

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| | | Fevers | | | Fatigue | | | Chronic cough |
| | | Visual disturbances | | | Loss of appetite | | | Shortness of breath |
| | | Depression | | | Weight loss | | | Wheezing |
| | | Anxiety | | | Weight gain | | | Tarry black stools |
| | | Throat irritation | | | Sinus infection | | | Diarrhea |
| | | Hoarse voice | | | Difficulty walking | | | Constipation |
| | | Difficulty swallowing | | | Numbness/tingling | | | Red blood in stool |
| | | Difficulty chewing | | | Muscle weakness | | | Frequent urination |
| | | Palpitations | | | Joint pain or swelling | | | Blood in urine |
| | | Chest pain | | | Sputum production | | | Easy bruising/bleeding |
| | | Skin rash/itching | | | Back Pain | | | Abdomen Pain |
| | | Other Pain: | | | | | | |

## B) MEDICATIONS ☐ None ☐ See attached list or

Please list all medications you are currently taking (include vitamins, herbal supplements, aspirin)

| Name of Medication | Dose taken | How often | Name of Medication | Dose taken | How often |
|---|---|---|---|---|---|
| | | | | | |

List **drug allergies**, including Latex allergy: _____

**Do you suffer from heartburn?** ☐ **NO** ☐ **YES**

If yes: How do you treat your heartburn? ☐ Diet ☐ Medications _____

Time of day your heartburn is worse: ☐ Day ☐ Night ☐ Both

**Were you born between 1945 and 1965?** ☐ **NO** ☐ **YES**

**Would you like to be tested for Hepatitis C?** ☐ **NO** ☐ **YES**

**Have you ever had a Screening Colonoscopy?** ☐ **NO** ☐ **YES**

**PATIENT'S SIGNATURE** (or representative's):_____

Print name: _____ Today's date: _____ (Revised 2/12)