Gregory K. Harmon, M.D

REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

Reason for Visit: _____

Please answer the following by circling "YES" or "NO"

- **Constitutional Symptoms**
  Fever/Chills **YES NO**
- **Skin**
  Itching or Dryness **YES NO**
- **Eyes**
  Visual Changes **YES NO**
- **Neurological**
  Headache/Dizziness **YES NO**
- **Respiratory**
  Shortness of Breath **YES NO**
- **Gastrointestinal**
  Difficulty Swallowing **YES NO**
- **Hematologic/Lymphatic**
  Any bleeding disorders? **YES NO**
- **Genitourinary**
  Urinate Frequently **YES NO**
- **Endocrine** **YES NO**
  Any hormonal or thyroid problems?
- **Musculoskeletal**
  Joint Pain/Swelling **YES NO**
- **Ear, Nose, Mouth, Throat**
  Hearing Changes **YES NO**
- **Psychiatric**
  Depression **YES NO**
- **Cardiovascular**
  Chest Pains **YES NO**

- **Do you have a history of:**
  Cancer **YES NO**
  If yes, what type of cancer do you have?
  _____
  High Blood Pressure **YES NO**
  Diabetes **YES NO**
  Thyroid Disease **YES NO**
  Eye Disease **YES NO**
  Other: _____
- **Do you have a family history of:**
  High Blood Pressure **YES NO**
  Heart Disease **YES NO**
  Diabetes **YES NO**
  Eye Disease **YES NO**
  Other: _____
- **Have you had …..**
  Surgery **YES NO**
  If yes, what type of surgery did you have? _____
- **Do you smoke? YES NO**
- **Do you drink? YES NO**
- **What medications are you currently taking? _____**
  _____
- **Do you have any allergies to medications? YES NO**
  If yes, which medications are you allergic to?
  _____

Patient's Signature: _____

Reviewed by M.D.: _____ CODE: _____ Date: _____