LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

Date: _____

Patient Name: _____ DOB: _____

Patient Review of Systems

Referred by: _____ Date of Injury/Onset of Symptoms: _____

Review of Systems

General		**Cardiac**	
Recent weight loss of more than 10 pounds?	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No
Recent weight gain of more than 10 pounds?	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Fever?	☐ Yes ☐ No		
Chills?	☐ Yes ☐ No	**Pulmonary**	
Night Sweats?	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No
Have you seen your Primary Care Physician in the last year? ☐ Yes ☐ No		Pneumonia	☐ Yes ☐ No
		Chronic Cough	☐ Yes ☐ No

Gastrointestinal		**Dermatological**		**Endocrine**	
Abdominal Pain	☐ Yes ☐ No	Open Sores	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Nausea	☐ Yes ☐ No	New Moles	☐ Yes ☐ No		
Vomiting	☐ Yes ☐ No	Poor Healing	☐ Yes ☐ No	**Dental**	
Diarrhea	☐ Yes ☐ No	Skin Infection	☐ Yes ☐ No	Significant problems	☐ Yes ☐ No
Liver Problems	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No		

Musculoskeletal		**Neurological**		**Genitourinary**	
Shoulder Pain	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Poor Kidney function	☐ Yes ☐ No
Wrist/hand Pain	☐ Yes ☐ No	Tremors	☐ Yes ☐ No	Pain with urination	☐ Yes ☐ No
Hip Pain	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Frequent UTI	☐ Yes ☐ No
Knee Pain	☐ Yes ☐ No	Change in vision	☐ Yes ☐ No		
Low Back Pain	☐ Yes ☐ No	**Psychological**		**Hematological**	
Lupus	☐ Yes ☐ No	Sleep trouble	☐ Yes ☐ No	Transfusion	☐ Yes ☐ No
Muscle Weakness	☐ Yes ☐ No	Feeling of Hopelessness	☐ Yes ☐ No	Transplant	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No			Blood Thinner	☐ Yes ☐ No

Patient Initials: _____ Date: _____