**Robert C. Hinkle, MD, FCCP, FAASM**
**The Baton Rouge Clinic, AMC**
**Pulmonary Department**

Name: _____ MRN: _____

# REVIEW OF SYSTEMS

Please check if you have/had problems related to the areas indicated.

| | | YES | NO |
|---|---|---|---|
| **1.** | **CONSTITUTIONAL** | | |
| | Weight Change | ☐ | ☐ |
| | Fever | ☐ | ☐ |
| | Night Sweats | ☐ | ☐ |
| | Fatigue | ☐ | ☐ |
| **2.** | **EYES** | | |
| | Glaucoma | ☐ | ☐ |
| | Cataracts | ☐ | ☐ |
| | Vision Surgery | ☐ | ☐ |
| **3.** | **EARS, NOSE, THROAT** | | |
| | Loss of Hearing | ☐ | ☐ |
| | Dizziness | ☐ | ☐ |
| | Nose Bleeding | ☐ | ☐ |
| | Gum Bleeding | ☐ | ☐ |
| **4.** | **RESPIRATORY** | | |
| | Chronic Cough | ☐ | ☐ |
| | Bronchitis | ☐ | ☐ |
| | Shortness of Breath | ☐ | ☐ |
| | Wheezing | ☐ | ☐ |
| | Coughed Up Blood | ☐ | ☐ |
| **5.** | **CARDIOVASCULAR** | | |
| | Heart Attack | ☐ | ☐ |
| | Chest Pain / Angina | ☐ | ☐ |
| | Heart Murmur | ☐ | ☐ |
| | Anemia | ☐ | ☐ |
| | Transfusions | ☐ | ☐ |
| | Phlebitis or Blood Clots | ☐ | ☐ |
| | Rheumatic Fever | ☐ | ☐ |
| **6.** | **GASTROINTESTINAL** | | |
| | Reflux | ☐ | ☐ |
| | Hepatitis A | ☐ | ☐ |
| | Blood in Stool | ☐ | ☐ |
| | Diarrhea / Constipation | ☐ | ☐ |
| | Hernia / Repair | ☐ | ☐ |
| | Gall Bladder Disease | ☐ | ☐ |

| | | YES | NO |
|---|---|---|---|
| **7.** | **ENDOCRINE SYSTEM** | | |
| | Diabetes | ☐ | ☐ |
| | Thyroid Problems | ☐ | ☐ |
| | Hormone Treatment | ☐ | ☐ |
| | Anabolic Steroids | ☐ | ☐ |
| **8.** | **BREAST / GENITAL** | | |
| | Menopause | ☐ | ☐ |
| | Masses | ☐ | ☐ |
| | Genital Infections | ☐ | ☐ |
| **9.** | **URINARY SYSTEMS** | | |
| | Urinary Tract / Bladder Infections | ☐ | ☐ |
| | Kidney Stones | ☐ | ☐ |
| | Incontinence | ☐ | ☐ |
| | Trouble Urinating | ☐ | ☐ |
| | Prostate Problems | ☐ | ☐ |
| **10.** | **SKIN** | | |
| | Cancer | ☐ | ☐ |
| | Rashes | ☐ | ☐ |
| **11.** | **NEUROLOGIC** | | |
| | Stroke | ☐ | ☐ |
| | Seizures | ☐ | ☐ |
| | Head Injury | ☐ | ☐ |
| | Nerve Damage | ☐ | ☐ |
| **12.** | **PSYCHIATRIC** | | |
| | Depression | ☐ | ☐ |
| | Anxiety | ☐ | ☐ |
| **13.** | **MUSCULOSKELETAL** | | |
| | Osteoarthritis | ☐ | ☐ |
| | Rheumatoid Arthritis | ☐ | ☐ |
| | Gout | ☐ | ☐ |
| **14.** | **OTHER** _____ | | |

_____

_____

_____

**Please bring this form with you to your appointment.**