



Beth Israel Deaconess Medical Center

Boston, MA 02215

REVIEW OF SYSTEMS QUESTIONNAIRE NEW OUTPATIENT

Division of Allergy & Inflammation

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

Dear Patient: Please read and carefully complete the following questionnaire.

REVIEW OF SYSTEMS:	Do you have or have you recently experienced any of the following?	No	Yes
Constitutional	Fever or chills		
	Weight loss or gain		
Eyes	Glaucoma		
Ears / Nose / Throat	Difficulty swallowing		
	Swelling of your tongue		
Nervous System	Have you ever passed out or lost consciousness?		
	Numbness or tingling in your arms or legs		
	Headaches		
	Blurred vision		
	Instability when walking		
Cardiovascular	Chest pain		
	Swelling in your ankles / feet		
	Heart skipping / pounding		
	Neck, jaw or arm pain that may be related to your heart		
	Cramping or tightness in your legs when walking		
Respiratory	Shortness of breath		
	Wheezing		
	Coughing up blood		
Gastrointestinal	Constipation or diarrhea		
	Nausea or vomiting		
	Do you have a history of ulcer disease?		
	Passing blood from your rectum or vomiting blood		
Genitourinary	Trouble initiating urination		
	Frequent urination		
Musculoskeletal	Joint aches, muscle aches or arthritis		
Skin	Skin rashes		
Hematologic / Lymphatic	Painful or enlarged glands		
	Bruising easily		
Psychiatric	Do you have a history of depression or other psychiatric illness?		

Patient Certification:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

X _____ or X _____ and _____ / ____ / ____
Patient's Signature Person authorized to sign for patient relationship to patient Date

Physician Review: I have reviewed the above information with the patient

X _____ M.D. _____ M.D. _____ / ____ / ____
Physician Signature Print Name Date