CARLISLE DIGESTIVE DISEASE ASSOCIATES, LTD.
Review of Systems Questionnaire

Please indicate whether you currently/recently have/had any of the following symptoms:

Recent increase in weight	____ NO	____ YES		**Neuro/Psychiatric**	____ NO	____ YES	
Recent decrease in weight	____ NO	____ YES		Headaches	____ NO	____ YES	
Fever	____ NO	____ YES		Memory loss	____ NO	____ YES	
Fatigue	____ NO	____ YES		Depression	____ NO	____ YES	
Cardiovascular				**Endocrine**			
Chest Pain	____ NO	____ YES		Do you often feel hot			
Shortness of breath	____ NO	____ YES		when other people around	____ NO	____ YES	
Palpitations	____ NO	____ YES		you do not?			
Swelling of ankles	____ NO	____ YES		Do you often feel cold			
Respiratory				when other people around	____ NO	____ YES	
Chronic cough	____ NO	____ YES		you do not?			
Spitting up blood	____ NO	____ YES		Excessive thirst	____ NO	____ YES	
Wheezing	____ NO	____ YES		Excessive urination	____ NO	____ YES	
Genitourinary				**Hematological**			
Burning with urination	____ NO	____ YES		Bruising tendency	____ NO	____ YES	
Blood in urine	____ NO	____ YES		Anemia	____ NO	____ YES	
Skin				Past transfusion	____ NO	____ YES	
Rash	____ NO	____ YES		**Other**			
Itching	____ NO	____ YES		Mouth sores	____ NO	____ YES	
Musculoskeletal				Dental disease or loose			
Joint Pain	____ NO	____ YES		teeth	____ NO	____ YES	
Back Pain	____ NO	____ YES		Sleep Apnea/C-PAP	____ NO	____ YES	
Gastrointestinal							
Poor appetite	____ NO	____ YES		If applicable, are you			
Difficulty in swallowing	____ NO	____ YES		pregnant?	____ NO	____ YES	
Heartburn	____ NO	____ YES					
Nausea or Vomiting	____ NO	____ YES		Infectious Diseases (at any time)			
Bloating	____ NO	____ YES		TB (Tuberculosis)	____ NO	____ YES	
Belching	____ NO	____ YES		MRSA	____ NO	____ YES	
Regurgitation	____ NO	____ YES		(methicillin resistant Staph aureus)			
Constipation	____ NO	____ YES		C. difficile	____ NO	____ YES	
Diarrhea	____ NO	____ YES					
Abdominal pain	____ NO	____ YES		Do you have a	____ NO	____ YES	
Recent change in bowel habits	____ NO	____ YES		Pacemaker/Defibrillator?			
Rectal Bleeding	____ NO	____ YES		Do you have a personal or family history of			
Black, tarry stools	____ NO	____ YES		malignant hyperthermia?	____ NO	____ YES	

Comments:

Form Reviewed By: _____ **Patients Name:** _____

Today's Date: _____ **Date of Birth:** _____