STUART M. HOMER MD
& ASSOCIATES
HYPERTENSION • NEPHROLOGY • INTERNAL MEDICINE

REVIEW OF SYSTEMS AND UPDATED PATIENT INFORMATION

KINDLY FILL OUT THIS FORM. IT WILL HELP US TO PROVIDE YOU WITH THE BEST CARE.
THIS INFORMATION IS REQUIRED BY YOUR INSURANCE COMPANY AND MEDICARE.

Patient Name: _____ **Date:** _____

CIRCLE ANY SYMPTOMS THAT SHOULD COME TO OUR ATTENTION

GENERAL
- ☐ FEVER
- ☐ CHILLS
- ☐ SWEATS
- ☐ WEIGHT LOSS/GAIN

GENITO-URINARY
- ☐ URINARY INFECTION
- ☐ DIFFICULTY URINATING
- ☐ EXCESSIVE URINATION
- ☐ BURNING

ENDOCRINE
- ☐ EXESSIVE THIRST
- ☐ EXCESSIVE HUNGER
- ☐ HEAT/COLD INTOLERANCE
- ☐ ABNORMAL HAIR GROWTH/LOSS

NEUROLOGIC
- ☐ WEAKNESS
- ☐ NUMBNESS
- ☐ DIFFICULTY MOVING

RESPIRATORY
- ☐ SHORTNESS OF BREATH
- ☐ PHLEGM

SKIN
- ☐ RASH
- ☐ ITCHING

GASTROINTESTINAL
- ☐ STOMACH PAIN/BURNING
- ☐ CONSTIPATION/DIARRHEA
- ☐ CHANGE IN APPETITE

HEMATOLOGIC
- ☐ FATIGUE
- ☐ EASY BRUISING

CARDIAC
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ BLACK OUT SPELLS

MUSCLE/JOINT
- ☐ ARTHRITIS
- ☐ MUSCLE PAIN
- ☐ JOINT SWELLING

ENT
- ☐ SINUS PAIN
- ☐ SORE THROAT
- ☐ HEARING PROBLEMS

EYES
- ☐ IMPAIRED VISION
- ☐ PAIN
- ☐ DOUBLE VISION

PSYCHIATRIC
- ☐ ANXIETY
- ☐ DEPRESSION

☐ **NO PROBLEMS**

☐ **SAME AS LAST VISIT**

☐ **OTHERS:**

INDICATE RECENT VISITS TO ANOTHER DOCTOR IN THE PAST SIX MONTHS:

DR: _____ DATE: _____ PROBLEM: _____

DR: _____ DATE: _____ PROBLEM: _____

DR: _____ DATE: _____ PROBLEM: _____

BEEN HOSPITALIZED: LOCATION: _____ DATES: _____

HAD BLOODWORK: LOCATION: _____ DATES: _____

HAD DIAGNOSTIC TESTING SUCH AS: MRI, ULTRASOUND, X-RAY, ECHO, STRESS TEST, COLONOSCOPY, ETC.

TEST: _____ DATE: _____ LOCATION: _____

TEST: _____ DATE: _____ LOCATION: _____

TEST: _____ DATE: _____ LOCATION: _____