

**STUART M. HOMER, MD and ASSOCIATES**  
**NEPHROLOGY - HYPERTENSION - INTERNAL MEDICINE**  
**NEW PATIENT REVIEW OF SYSTEMS**

Patient's Name \_\_\_\_\_ Date \_\_/\_\_/\_\_

DOB \_\_/\_\_/\_\_ Age \_\_ Date of Last Physical Examination \_\_/\_\_/\_\_

**PLEASE CHECK ANY CONDITIONS/SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR**

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| <p><b><u>GENERAL</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Trouble Sleeping</li> <li><input type="checkbox"/> Weight Change</li> <li><input type="checkbox"/> Fever/Chills</li> </ul> <p><b><u>GENITO-URINARY</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Excessive Urination</li> <li><input type="checkbox"/> Difficulty Urination</li> <li><input type="checkbox"/> Burning/Pain on Voiding</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Blood in Urine</li> <li><input type="checkbox"/> Passing Urine at Night</li> <li><input type="checkbox"/> Difficulty Obtaining Erection</li> <li><input type="checkbox"/> Irregular Menstrual Cycle</li> </ul> <p><b><u>CARDIOVASCULAR</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest Pain or Discomfort</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Irregular Heart Beat</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Low Blood Pressure</li> <li><input type="checkbox"/> Swelling of Ankles Varicose Veins</li> <li><input type="checkbox"/> Pain in Calves or Buttocks While Walking Leg Cramping</li> </ul> <p><b><u>RESPIRATORY</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Sputum Production</li> <li><input type="checkbox"/> Congestion</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Painful Breathing</li> </ul> | <p><b><u>GASTROINTESTINAL</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> Nausea/Vomiting</li> <li><input type="checkbox"/> Blood in Stool</li> <li><input type="checkbox"/> Alteration in Bowel Habits</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Indigestion</li> </ul> <p><b><u>EARS / NOSE / THROAT</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sinus Pain</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Ringing in Ears</li> <li><input type="checkbox"/> Decreased Hearing</li> <li><input type="checkbox"/> Sore Throat</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Swollen Glands</li> <li><input type="checkbox"/> Dental Issues</li> </ul> <p><b><u>NEUROLOGIC</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Vertigo/Dizziness</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Numbness/Tingling</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Gait Disturbance</li> <li><input type="checkbox"/> Memory Loss</li> </ul> <p><b><u>ENDOCRINE</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Increased Thirst</li> <li><input type="checkbox"/> Change in Appetite</li> <li><input type="checkbox"/> Heat/Cold Intolerance</li> <li><input type="checkbox"/> Sweating</li> </ul> | <p><b><u>MUSCLE/JOINT/BONE</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle or Joint Pain</li> <li><input type="checkbox"/> Stiffness</li> <li><input type="checkbox"/> Back Pain</li> <li><input type="checkbox"/> Redness of Joints</li> <li><input type="checkbox"/> Swelling of Joints</li> <li><input type="checkbox"/> Sciatica</li> </ul> <p><b><u>IMMUNOLOGIC</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seasonal Allergies</li> <li><input type="checkbox"/> Runny Nose</li> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Itchy Eyes</li> </ul> <p><b><u>SKIN</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Itchiness Change in Moles</li> <li><input type="checkbox"/> Non Healing Lesions</li> <li><input type="checkbox"/> Hair/Nail Changes</li> </ul> <p><b><u>EYES</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Impaired Vision</li> <li><input type="checkbox"/> Retinopathy or Cataracts</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Corrective Lenses</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Redness</li> <li><input type="checkbox"/> Blurry or Double Vision</li> </ul> <p><b><u>HEMATOLOGIC</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bruise Easily</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Change in Bleeding Tendency</li> </ul> <p><b><u>PSYCHIATRIC</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Stress</li> </ul> |
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