Lancaster Office:
810 Plaza Boulevard
Lancaster, PA 17601
Office 717-394-5088
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561 W. Trout Run Road
Ephrata, PA 17522
Office: 717-733-4891
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Review of Systems

DATE: ______________________________

NAME: ____ BIRTHDATE: ___________________________

REASON FOR TODAY'S VISIT: ____

IS THE PATIENT CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

		Yes	No
CONSTITUTIONAL	Fever/Chills	☐	☐
EYES	Excessive Tearing	☐	☐
CARDIAC	Edema (swelling)	☐	☐
RESPIRATORY	Wheezing/Asthma	☐	☐
GASTROINTESTINAL	Diarrhea	☐	☐
INTEGUMENT (SKIN)	Non-Healing Sores	☐	☐
NEUROLOGIC	Seizures	☐	☐
MUSCULOSKELETAL	Limitation of Motion	☐	☐
ENDOCRINE	Excessive Thirst	☐	☐
HEMATOLOGIC (HEME-LYMPH)	Easy Bruising/Bleeding	☐	☐

HEALTH AND PREVENTATIVE SCREENING	
HAVE YOU HAD ANY OF THE FOLLOWING?	
PNEUMONIA VACCINE - EVER	☐ YES ☐ NO
INFLUENZA VACCINE -	☐ YES ☐ NO

	Right Ear	Both Ears	Left Ear
HEARING LOSS	☐	☐	☐
TINNITUS (NOISE IN EAR)	☐	☐	☐
PRESSURE/FULLNESS SENSATION	☐	☐	☐
EAR PAIN	☐	☐	☐
EAR DRAINAGE	☐	☐	☐

Please Check Social Behavior and Indicate how often, if former indicate former		
	How much?	How Often?
TOBACCO - SMOKE OR CHEW		
ALCOHOL		

Clinical USE Only

Review of Medications Completed ☐

Completed by: ____