PARAGON
INFUSION CENTERS

REVIEW OF SYSTEMS

FULL NAME: _____ **DOB:** _____

Please check any current symptoms you are experiencing:

GENERAL:

☐ Weight loss (>10 pounds) ☐ Fever/chills ☐ Fatigue (tiredness) ☐ Night sweats

EYES:

☐ Vision loss/blurring ☐ Eye pain ☐ Eye redness ☐ Dry eyes ☐ Drainage ☐ Double vision

EAR / NOSE / THROAT / MOUTH:

☐ Sore throat ☐ Earache ☐ Nasal congestion/drainage ☐ Loss of hearing ☐ Mouth ulcers
☐ Toothache/dental problems Last dental exam date: _____

CARDIOVASCULAR:

☐ Chest pain ☐ Palpitations ☐ Irregular heartbeat ☐ Lower leg/ankle swelling

RESPIRATORY:

☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Snoring

HEMA/LYMPH:

☐ Easy bruising ☐ Nose bleeds ☐ Enlarged lymph nodes

URINARY:

☐ Urinary urgency ☐ Urinary frequency ☐ Blood in urine ☐ Burning with urination
☐ Incontinence ☐ Vaginal discharge/lesions

MUSCULOSKELETAL:

☐ Weakness ☐ Neck pain ☐ Back pain ☐ Joint swelling ☐ Muscle pain
☐ Joint pain Pain on a scale of 1-10: _____ Pain location: _____

DERM:

☐ Rash ☐ Skin lesions ☐ Hair loss ☐ Nail change

NEURO:

☐ Headaches ☐ Passing out ☐ Confusion ☐ Dizziness ☐ Numbness/tingling in extremities
☐ Light sensitivity ☐ Sound sensitivity ☐ Visual floaters

PSYCH:

☐ Depression ☐ Anxiety ☐ Poor appetite ☐ Difficulty sleeping

GASTRO:

☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea __ times/day ☐ Bloody stool ☐ Constipation

SOCIAL HISTORY:

☐ Tobacco/nicotine use: ☐ Cigarettes (# daily __) ☐ Pipe ☐ Snuff/dip/chew ☐ Vape ☐ Cigars
☐ Past user Year quit: _____ OR Age started: ___ and age quit: ___

☐ Alcohol use: ☐ Wine ☐ Beer ☐ Liquor Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

☐ Caffeine use: Type: _____ Amount daily: _____

☐ Drug use: Type: _____ Do you exercise regularly? ☐ Yes ☐ No

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PAST MEDICAL HISTORY

FULL NAME: _____ **DOB:** _____

Please check anything in your medical history:

ENDOCRINE:

☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Thyroid problems

EYES:

☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Optic Neuritis

CARDIOVASCULAR:

☐ Pacemaker/defibrillator ☐ Irregular heart beat (i.e., A-fib) ☐ Heart surgery ☐ Heart murmur
☐ High blood pressure ☐ High cholesterol or triglycerides ☐ Congestive heart failure

RESPIRATORY:

☐ Asthma ☐ Emphysema ☐ COPD ☐ Sleep apnea ☐ Seasonal allergies ☐ Bronchitis ☐ History of TB

GASTROINTESTINAL:

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon surgery/resection ☐ Ileostomy/colostomy ☐ Stomach ulcer
☐ Hep B or Hep C ☐ Irritable bowel syndrome ☐ Fatty liver or Cirrhosis ☐ Reflux disease ☐ Pancreatitis

PSYCH:

☐ Depression ☐ Anxiety ☐ Bipolar ☐ Suicidal thoughts/attempts

MEN'S HEALTH:

☐ Enlarged prostate ☐ Prostate cancer

MUSCULOSKELETAL:

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Fibromyalgia ☐ Arthritis
☐ History of bone fracture (location: _____) ☐ Osteoporosis/osteopenia (weak bones)

OTHER AUTOIMMUNE/IMMUNE DISORDERS:

☐ Lupus ☐ Sjogren's ☐ Scleroderma ☐ HIV ☐ Vasculitis ☐ Immune deficiency
☐ Polymyositis ☐ Neuromyelitis Optica

NEURO:

☐ Stroke ☐ Migraines ☐ Multiple Sclerosis ☐ Seizures ☐ Parkinson's Disease ☐ CIDP
☐ Traverse Myelitis ☐ Other: _____

DERMATOLOGY:

☐ Psoriasis ☐ Skin cancer (Type: _____) ☐ Urticaria ☐ Eczema

URINARY:

☐ Frequent infections (UTIs) ☐ Bladder Prolapse

WOMEN'S HEALTH:

☐ Last cycle date: _____ ☐ Hysterectomy ☐ Tubal ligation ☐ Breast/ovarian/cervical cancer ☐ Infertility

HEMA/LYMPHATIC:

☐ Anemia ☐ History of blood transfusions ☐ Blood clots (extremities or lungs) ☐ Sickle cell anemia

OTHER MEDICAL HISTORY:

PERTINENT FAMILY HISTORY RELATED TO YOUR VISIT:

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HEALTH QUESTIONNAIRE

FULL NAME: _____ **DOB:** _____

PLEASE ANSWER THE FOLLOWING:

Have you had a pneumonia vaccine (pneumovax/prevnar)? ☐ Yes ☐ No Last known date: _____

Have you had flu vaccine? ☐ Yes ☐ No Last known date: _____

SURGERY HISTORY:

NEW PATIENTS: Please list all surgeries

ESTABLISHED PATIENTS: Please list all new surgeries within the last year

SURGERY TYPE:	MONTH/YEAR:

IF 65 AND OLDER, PLEASE ANSWER THE FOLLOWING:

Have you had any falls within the last year? ☐ Yes ☐ No

If yes, how many falls in the last year? _____ Did the fall result in injury? _____

Do you use any assistive devices when walking? ☐ Yes ☐ No

☐ Cane ☐ Crutch/crutches ☐ Walker ☐ Wheelchair ☐ Other: _____