OPTUM®

1625 Medical Center Point, #260
Colorado Springs, CO 80907

Pulmonary medicine–review of systems (male)

Patient name ______________________________ Date of birth ____________________

Please check any symptom below that you have. Ask your provider if you do not understand the question or want to give more specific details.

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Feeling poorly
- ☐ Feeling tired
- ☐ Recent weight gain________ lbs
- ☐ Recent weight loss ________ lbs

Eyes

- ☐ Eye pain
- ☐ Red eyes
- ☐ Eyesight problems
- ☐ Discharge from eyes
- ☐ Dry eyes
- ☐ Eyes itch

Ear, Nose, Throat

- ☐ Earache
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Nasal discharge
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Fast heart rate
- ☐ Slow heart rate
- ☐ Leg cramps with exercise
- ☐ Swelling of lower leg(s)

Respiratory

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Short of breath at night
- ☐ Short of breath when laying flat
- ☐ Short of breath with activity

Gastrointestinal

- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Black/bloody bowel movements

Genitourinary

- ☐ Pain with urination
- ☐ Urine leaking
- ☐ Slow starting urine
- ☐ Pain in testicles
- ☐ Sores on penis or nearby skin
- ☐ Urinating frequently at night

Musculoskeletal

- ☐ Achy joints
- ☐ Pain in joints
- ☐ Swelling in joints
- ☐ Stiff joints
- ☐ Pain in arms or legs
- ☐ Swelling of lower leg(s)

Integumentary

- ☐ Abnormal patch of skin
- ☐ Skin wound
- ☐ Itching
- ☐ Change in a mole
- ☐ Dry skin
- ☐ Any unusual growth or lump

Neurological

- ☐ Confusion
- ☐ Seizures or convulsion
- ☐ Dizziness
- ☐ Fainting
- ☐ Weak or numb limb
- ☐ Difficulty walking

Psychiatric

- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Change in personality
- ☐ Disturbed sleep
- ☐ Depression
- ☐ Emotional problems

Endocrine

- ☐ Bulging eye(s)
- ☐ Feeling of weakness
- ☐ General muscle weakness
- ☐ Hot flashes
- ☐ Deepening of the voice

Heme/Lymph

- ☐ Easy bleeding
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Swollen neck glands

Other problems (please explain):

____

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Sleep history

- ☐ Daytime sleepiness
- ☐ Insomnia
- ☐ Waking frequently at night
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Urge to move legs at rest or in bed
- ☐ Helps to move legs
- ☐ Change in sleep pattern

When is your bedtime? ______________________________

How long does it take you to fall asleep? ______________________________

How many times do you awaken at night? ______________________________

What time do you wake up in the morning? ______________________________

How many hours of sleep do you get at night? ______________________________

Tuberculosis

Do you know if you've had exposure to someone with TB? ☐ No ☐ Yes

Have you had previous TB tests? ☐ No ☐ Yes If yes, result: ______________________________

Have you had any treatment for positive TB test? ☐ No ☐ Yes

Have you had any diagnosis of active TB? ☐ No ☐ Yes, treatment used ______________________________

Treatment lasted ______________________________ months

Patient's signature ______________________________ Date ______________________________

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