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Review of Systems

Please check any of the following problems that apply to you personally.

GENERAL HEALTH

Good general health lately _____
Recent weight change _____
Fever _____
Fatigue _____
Headaches _____
Loss of appetite _____

EYES

Eye disease or injury _____
Wear glasses / contact lens _____
Blurred or double vision _____
Glaucoma _____

EAR / NOSE / MOUTH / THROAT

Hearing loss or ringing _____
Earaches or drainage _____
Chronic sinus problem or rhinitis _____
Nose bleeds _____
Mouth sores _____
Bleeding gums _____
Bad breath or bad taste _____
Sore throat or difficulty swallowing _____
Swollen glands in neck _____

CARDIOVASCULAR

History of pulmonary embolism _____
Heart trouble _____
Chest pain or angina pectoris _____
Palpation _____
Shortness of breath with walking or lying flat _____
Severe cramping in legs when walking _____
Swelling of feet, ankles or hands _____

RESPIRATORY

Chronic or frequent coughs _____
Spitting up blood _____
Shortness of breath _____
Asthma or wheezing _____

GASTROINTESTINAL

Loss of appetite _____
Change in bowel movements _____
Nausea or vomiting _____
Frequent diarrhea _____
Painful bowel movements or constipation _____
Rectal bleeding or blood in stool _____
Abdominal pain or heartburn _____
Peptic ulcer (stomach or duodenal) _____

GENITOURINARY

Frequent urination _____
Burning or painful urination _____
Blood in urine _____
Change in force or strain when urinating _____
Incontinence or dribbling _____
Kidney stones _____
Sexual difficulty _____
Urinary tract infections _____
Enlarged prostate _____

MUSCULOSKELETAL

Joint pain, stiffness or swelling _____
Shooting leg pain _____
Weakness of muscles or joints _____
Muscle pain or cramps _____
Back pain _____
Cold extremities _____
Difficulties in walking or standing _____
Frequent dislocations _____

SKIN CONDITIONS (skin, breast)

Rash or itching _____
Change in skin color _____
Change in hair or nails _____
Varicose veins _____
Breast pain / lump / discharge _____
Painful bumps on the skin _____

NEUROLOGICAL

Frequent or recurring headaches _____
Nighttime cramps _____
Convulsions or seizures _____
Numbness or tingling sensations _____
Tremors _____
Paralysis _____
Stroke _____
Head injury _____
Claustrophobia _____

PSYCHIATRIC

Memory loss or confusion _____
Nervousness _____
Panic attacks _____
Depression _____
Insomnia _____

ENDOCRINE

Glandular or hormone problem _____
Thyroid disease _____
Diabetes _____
Excessive thirst or urination _____
Heat or cold intolerance _____
Skin becoming dryer _____
Excessive facial hair _____

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts _____
Bleeding or bruising tendency _____
Anemia _____
Phlebitis or Blood clot _____
Past transfusion – blood or platelet _____
Enlarged glands _____

ALLERGIC / IMMUNOLOGIC

History of skin reaction or other adverse reaction _____
Penicillin or other antibiotics _____
Morphine, Demerol or other narcotics _____
Novocaine or other anesthetics _____
Aspirin or other pain remedies _____
Tetanus antitoxin or other serums _____
Iodine, merthiolate or other antiseptics _____