

## REVIEW OF SYSTEMS

Name \_\_\_\_\_ Date \_\_\_\_\_

*Please check or circle all the items below that apply to you.*

### Constitutional Symptoms

- Fever
- Weight Loss
- Cold in Last 2 Weeks

### Eyes

- Change in Vision
- Double Vision

### ENT

- Hard of Hearing
- Ringing in your ears
- Dizziness
- Sinusitis
- Nosebleeds
- Dental Problems/Loose Teeth
- Loss of Taste
- Hoarseness

### Cardiovascular

- Chest Pain
- Palpitations
- Previous Heart Attack
- Rapid Heartbeat
- Shortness of Breath
- Valvular Heart Disease

### Respiratory

- Asthma/Bronchitis
- Cough
- Emphysema/COPD
- Sleep Apnea
- Wheezing

### Gastrointestinal

- Abdominal Pain
- Belching
- Change in Bowel Habits
- Difficulty Swallowing
- Excess Gas
- History of Polyps
- Jaundice
- Loss of Appetite
- Nausea/Vomiting
- Previous Transfusions
- Rectal Bleeding

### Genitourinary

- Difficult Urination
- Incontinence
- Kidney Stones
- Urinating at Night

### Musculoskeletal

- Arthritis
- Body Aches
- Joint Replacements
- Neck Pain/Injury
- Previous Fractures
- TMJ

### Integumentary

- Bruising
- Change in Hair
- Itching

### Neurological

- Headaches
- Numbness
- Seizures
- Weakness

### Psychiatric

- Depression
- Insomnia
- Panic Attacks
- Suicide Attempts

### Endocrine

- Diabetes
- Excessive thirst or hunger
- Goiter
- Hair loss
- Menstrual problems
- Thyroid problems

### Hematological/Lymphatic

- Anemia
- Enlarged lymph node

### Allergic/Immunologic

- Allergies
- Eczema
- Hay fever
- Immunizations

Patient Signature \_\_\_\_\_



## Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, \_\_\_\_\_, hereby give my consent to Elgin Gastroenterology to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of \_\_\_\_\_  
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me in a reasonable period of time in writing.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I also authorize the release of medical information and appointment information to the following people:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient

\_\_\_\_\_.