Kootenai Occupational Medicine

Review of Systems

Name: _____ Date: _____

Constitutional Symptoms:
Good general health lately __No __Yes
Recent weight change __No __Yes
Fever __No__ Yes
Fatigue __No__Yes

Ears/Nose/Mouth/Throat:
Hearing loss or ringing __No__Yes
Earaches or drainage __No__Yes
Chronic sinusitis or rhinitis __No__Yes
Nose bleed __No__Yes
Bleeding gums __No__Yes
Bad breath or taste __No__Yes
Sore throat or voice change __No__Yes
Difficulty swallowing __No__Yes

Neurological:
Frequent headaches __No__Yes
Light headed/dizzy __No__Yes
Convulsions/seizures __No__Yes
Numbness/tingling __No__Yes
Tremors __No__Yes
Paralysis or stroke __No__Yes
Head injury __No__Yes

Musculoskeletal:
Joint pain __No__Yes
Joint stiffness or swelling __No__Yes
Weakness joints/muscles __No__Yes
Muscle pain or cramps __No__Yes
Back pain __No__Yes
Cold extremities __No__Yes
Difficulty walking __No__Yes

Cardiovascular:
Heart trouble __No__Yes
Chest Pain __No__Yes
Palpitations __No__Yes
Swelling feet, ankles, hands __No__Yes
Heart murmur __No__Yes
Hypertension __No__Yes
Heart attack __No__Yes

Endocrine:
Thyroid disease __No__Yes
Diabetes __No__Yes
Excessive thirst/urination __No__Yes
Heat/cold intolerance __No__Yes

Gastrointestinal:
Loss of appetite __No__Yes
Change in bowel movement __No__Yes
Painful bowel movement __No__Yes
Nausea/vomiting __No__Yes
Frequent diarrhea __No__Yes
Constipation __No__Yes
Rectal bleeding __No__Yes
Black bowel movement __No__Yes
Blood in stool __No__Yes
Abdominal Pain __No__Yes
Peptic Ulcer __No__Yes

Psychiatric:
Memory loss or confusion __No__Yes
Nervousness/Insomnia __No__Yes
Depression/Anxiety __No__Yes
Mental illness __No__Yes
Psychiatric hospitalization __No__Yes
Bipolar disease __No__Yes

Eyes:
Eye disease or injury __No__Yes
Wear glasses/contacts __No__Yes
Blurred/double vision __No__Yes
Glaucoma __No__Yes

Genitourinary:
Frequent urination __No__Yes
Burning/painful urination __No__Yes
Blood in urine __No__Yes
Incontinence/dribbling __No__Yes
Difficulty urinating __No__Yes
Kidney stones __No__Yes
Sexual difficulty __No__Yes
Male testicle pain __No__Yes
Female pain during period __No__Yes
Female irregular period __No__Yes
Female vaginal discharge __No__Yes

Respiratory:
Chronic/frequent cough __No__Yes
Spitting up blood __No__Yes
Shortness of breath __No__Yes
Asthma/wheezing __No__Yes
Emphysema __No__Yes

Skin:
Rash or itching __No__Yes
Change in skin color __No__Yes
Change in hair/nails __No__Yes
Varicose veins __No__Yes
Breast pain __No__Yes
Breast lump __ No__Yes
Breast discharge __No __Yes

Hematological/Lymphatic:
Slow to heal after cuts __No__Yes
Bleed/bruise easily __No__Yes
Anemia/transfusion __No__Yes
Phlebitis __No__Yes
Swollen gland __No__Yes
Hepatitis __No__Yes

Allergic/Immunologic:
Latex allergy __No__Yes
Food allergy __No__Yes
Environmental allergy __No__Yes

Doctor/ARNP Initials:_____ Date:_____

Kootenai Occupational Medicine

Occupational History

Name: _____ Date:_____

Have you ever worked with:

	Yes	No	Comments
Chemicals	___	___	_____
Vapors/gasses	____	____	_____
Metals/minerals	___	___	_____
Fumes	___	___	_____
Radiation	___	___	_____
Chemotherapy	___	___	_____
Dust	___	___	_____
Vibrations	___	___	_____
Loud Noises	___	___	_____
Asbestos	___	___	_____

Has your work ever been limited or restricted on account of your health? Yes____No_____

Have you ever lost time from work due to illness or injury during the past Two years? Yes____ No_____

Have you ever filed a compensation claim or received benefits as a result Of a work related injury or illness? Yes____ No_____

Have you ever received disability benefits from an employer or social security? Yes___ No_____

Have you ever been disqualified for duty in or discharged from the armed forces For medical reasons? Yes____No_____

If you answered yes to any of the above questions, please give an explanation of the circumstances below. Be sure to include specific details.

_____

_____

_____

_____

_____

Doctor/ARNP's initials:_____ Date:_____