Treasure Valley Gastroenterology Specialists
Raquel Croitoru, M.D.
Board Certified Gastroenterology
Fellow American College of Gastroenterology

Patient: _____ **DOB:** _____ **DOS:** _____

REVIEW OF SYSTEMS

Please indicate, on all items, if you have experienced the symptom now, in the last three months, or not at all:

YES NOW	LAST 3 MO	NO	GENERAL
☐	☐	☐	Feel Tired / Worn Out
☐	☐	☐	Feel Too Hot / Cold
☐	☐	☐	Chill / Fever / Sweats
☐	☐	☐	Feel Depressed
☐	☐	☐	Weight Gain Lbs _____
☐	☐	☐	Weight Loss Lbs _____

NOW	3 MO	NO	ENDOCRINE/HEMATOLOGICAL
☐	☐	☐	Swollen Glands
☐	☐	☐	Been Anemic
☐	☐	☐	Bleed For Prolonged Time Periods
☐	☐	☐	Bruise Easily

NOW	3 MO	NO	VISION
☐	☐	☐	Sensitivity To Light
☐	☐	☐	Pain In Your Eyes
☐	☐	☐	Blurry Vision
☐	☐	☐	Change In Vision
☐	☐	☐	Glaucoma

NOW	3 MO	NO	GENITOURINARY
☐	☐	☐	Burning / Painful Urination
☐	☐	☐	Frequent Urination
☐	☐	☐	Difficulty Urinating
☐	☐	☐	Blood In The Urine
☐	☐	☐	Incontinence (Urine Leakage)
☐	☐	☐	Brown/Coke Colored Urine
☐	☐	☐	I Think/Have A Urinary Infection

NOW	3 MO	NO	EAR/NOSE/THROAT
☐	☐	☐	Trouble Hearing
☐	☐	☐	Ear Pain
☐	☐	☐	Stuffy Nose
☐	☐	☐	Sinus Pain
☐	☐	☐	Lump In Throat
☐	☐	☐	Sore Tongue / Mouth
☐	☐	☐	Burning In Throat
☐	☐	☐	Hoarseness
☐	☐	☐	Nose Bleeds
☐	☐	☐	Mouth Sores/Ulcers

YES NOW	LAST 3 MO	NO	RESPIRATORY
☐	☐	☐	Cough
☐	☐	☐	Difficulty Breathing – At Rest
☐	☐	☐	Difficulty Breathing – W/Exertion
☐	☐	☐	Difficulty Breathing – Lying Down
☐	☐	☐	Shortness Of Breath
☐	☐	☐	Wheezing

NOW	3 MO	NO	MUSCULOSKELETAL
☐	☐	☐	Pain / Ache In Muscles
☐	☐	☐	Pain / Ache In Joints
☐	☐	☐	Difficulty Walking
☐	☐	☐	Swelling In Joints

NOW	3 MO	NO	CARDIOVASCULAR
☐	☐	☐	Pain / Pressure In Chest – At Rest
☐	☐	☐	Pain / Pressure In Chest – W/Activity
☐	☐	☐	Swelling In Feet / Ankles
☐	☐	☐	Irregular Heart Beat
☐	☐	☐	Altered Heart Beat: Fast? Slow? (Circle One)

NOW	3 MO	NO	SKIN
☐	☐	☐	Skin Rashes / Itching
☐	☐	☐	Changes In Hair / Nails
☐	☐	☐	Skin Changed Color
☐	☐	☐	Dry Skin
☐	☐	☐	Open Sores
☐	☐	☐	Skin Infections w/MRSA

NOW	3 MO	NO	NERVOUS SYSTEM
☐	☐	☐	Frequent Headaches
☐	☐	☐	Memory Loss
☐	☐	☐	Poor Balance
☐	☐	☐	Tingling In Arms / Legs
☐	☐	☐	Dizziness / Fainting
☐	☐	☐	Seizures
☐	☐	☐	Tremors/Repetitive Movements
☐	☐	☐	Weakness In Legs

NOW	3 MO	NO	WOMEN ONLY
☐	☐	☐	Abnormal Menstrual Periods
☐	☐	☐	Lumps In Breasts
☐	☐	☐	Passed Menopause
☐	☐	☐	Nipple Discharge
☐	☐	☐	Pregnant (let us know if this changes)

222 W. Iowa Ave. Ste A ● Nampa, ID 83686 Phone: 208-467-3432 Fax: 208-467-4147

Patient: _____ **DOB:** _____ **DOS:** _____

REVIEW OF SYSTEMS (CONT)

YES NOW	LAST 3 MO	NO	GASTROINTESTINAL
☐	☐	☐	Nausea
☐	☐	☐	Vomiting / What Comes Up _____
☐	☐	☐	Difficulty Swallowing
☐	☐	☐	Food Sticks In Throat
☐	☐	☐	Pills Sticks In Throat
☐	☐	☐	Food Coming Up to Throat
☐	☐	☐	Burning In Chest
☐	☐	☐	Burning In Stomach
☐	☐	☐	Ever Had Ulcers / When _____
☐	☐	☐	Decrease In Appetite
☐	☐	☐	Pain When Eating
☐	☐	☐	Filling Full Easily When Eating
☐	☐	☐	Red Rectal Bleeding
☐	☐	☐	Black Stools
☐	☐	☐	Liver Disease / When _____
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Use Laxatives At Least Once A Week / How Often _____
☐	☐	☐	Change In Bowels
☐	☐	☐	Can't Control Bowels
☐	☐	☐	Abdominal Pain / Where _____
☐	☐	☐	Bloating / Gas
☐	☐	☐	Food Intolerances / What _____

Please list any other symptoms that you think may be important: