

(Office Only) MRN: _____



Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP

PATIENT NAME: _____

DOB: ___/___/___ AGE: _____ SEX: M / F

Date: ___/___/___

Form completed by: Patient Parent/Guardian: _____

Review of Systems:

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: Fever Chills Fatigue Loss of appetite Weight loss Weight gain

Skin: Rash Itching Hives Dryness Frequent skin infections

Head: Headache Sinus pressure Sinus tenderness

Eyes: Itchy eyes Red eyes Burning eyes Watery eyes

Ears: Itchy ears Frequent ear infections Ear tubes

Nose: Itchy nose Sneezing Runny nose Nasal congestion Frequent sinus infections

Throat: Heart burn Difficulty swallowing Feeling food getting stuck Painful swallowing

Respiratory: Cough Shortness of breath Wheezing Chest tightness Frequent pneumonias

Cardiovascular: Chest pain Palpitations History of fainting

Gastrointestinal: Nausea Vomiting Abdominal pain Diarrhea Blood in the stool Constipation Liver problems

Genitourinary: Kidney problems Kidney stones Frequent infections Incontinence

Musculoskeletal: Muscle pain Joint pain Joint swelling

Endocrine: Frequent urination Thirst Heat or cold intolerance

Neurological: Seizures Learning problems Migraines Numbness/tingling in extremities

Psychiatric: Stress Depression Anxiety Behavioral problems

Other Symptoms: Please List: _____

Review of Systems Completed: _____

Patient Signature

Influenza Vaccine (this season from
September to April): Yes No

If you have not received the flu shot this
season, would you like it to be administered at
this office visit? Yes No