QUEEN'S ISLAND URGENT CARE

Tel: (808)735-0007
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Review of Systems

Patient Name: ___________________________ Date of Birth:____________ Date of Service:___________

Please check Yes or No for any symptoms related to TODAY'S visit.

CONSITUTIONAL:	**EYES:**	**ENT/MOUTH:**
FATIGUE: □ Yes □ No	BLURRED VISION: □ Yes □ No	RUNNY NOSE: □ Yes □ No
FEVER: □ Yes □ No	EYE REDNESS: □ Yes □ No	EARACHE: □ Yes □ No
CHILLS: □ Yes □ No	PAIN IN EYE(S) : □ Yes □ No	SORE THROAT: □ Yes □ No
CARDIO:	**RESPIRATORY:**	**GI (GASTROINTESTINAL):**
CHEST PAIN: □ Yes □ No	COUGH: □ Yes □ No	ABDOMINAL PAIN: □ Yes □ No
PALPITATIONS: □ Yes □ No	SHORT OF BREATH: □ Yes □ No	DIARRHEA: □ Yes □ No
SWELLING IN LEG: □ Yes □ No	WHEEZING: □ Yes □ No	VOMITING: □ Yes □ No
GU (GENITOURINARY):	**MUSC/SKEL:**	**SKIN:**
BLOOD IN URINE: □ Yes □ No	MUSCLE ACHES: □ Yes □ No	ABRASION: □ Yes □ No
URINARY PAIN: □ Yes □ No	PAIN IN JOINTS: □ Yes □ No	LACERATION: □ Yes □ No
VAGINAL DISCHARGE: □Yes □No	PAIN IN BACK : □ Yes □ No	RASH : □ Yes □ No
BREAST:	**HEME/LYMPH:**	**ALLERGY/IMMUN:**
LUMP IN BREAST: □ Yes □ No	BLOODY NOSE: □ Yes □ No	HIVES: □ Yes □ No
NIPPLE BLEEDING: □ Yes □ No	EASY BRUISING: □ Yes □ No	ITCHY EYES: □ Yes □ No
NIPPLE DISCHARGE:□ Yes □ No	LYMPH SWELLING: □ Yes □ No	SNEEZING : □ Yes □ No
NEUROLOGIC:	**PSYCHIATRIC:**	**ENDOCRINE:**
DIZZINESS: □ Yes □ No	ANXIETY: □ Yes □ No	EXCESS HUNGER: □ Yes □ No
HEADACHE: □ Yes □ No	DEPRESSION: □ Yes □ No	EXCESS THIRST: □ Yes □ No
NUMBNESS : □ Yes □ No	INSOMNIA : □ Yes □ No	WEIGHT CHANGE: □ Yes □ No

☐ **CHECK HERE TO ANSWER "NO" TO ALL SYMPTOMS LISTED ABOVE.**

PATIENT (or Guardian/Parent) SIGNATURE: ____

PARENT / GUARDIAN NAME: _____________________________ RELATION TO PATIENT: ________________

OFFICE USE ONLY

VID# _____________ *QIUC STAFF: SIGN AFTER REVIEWING & ENTERING INTO EMR.*

M.A. SIGNATURE: ____________________ PROVIDER SIGNATURE: __________________________