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**Casco Bay Gastroenterology, LLC**  
**Casco Bay Endoscopy Center**

**FOLLOW-UP REVIEW OF SYSTEMS**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

**MEDICATIONS**

Are there any changes to your medications since your last visit? Yes No If Yes, list changes below.		
Medications:	Dosage:	Frequency:

**REVIEW OF SYSTEMS (Please check Yes or No for all items)**

<p><b>Constitutional</b></p> <p>Recent weight change ___ No ___ Yes</p> <p>Fever ___ No ___ Yes</p> <p>Fatigue ___ No ___ Yes</p> <p><b>Eyes</b></p> <p>Blurred vision ___ No ___ Yes</p> <p>Glaucoma ___ No ___ Yes</p> <p><b>ENT</b></p> <p>Hearing loss ___ No ___ Yes</p> <p>Ringing in ears ___ No ___ Yes</p> <p>Mouth sores ___ No ___ Yes</p> <p><b>Cardiovascular</b></p> <p>Chest pain ___ No ___ Yes</p> <p>Shortness of breath ___ No ___ Yes</p> <p>Swelling of ankles ___ No ___ Yes</p> <p><b>Respiratory</b></p> <p>Chronic cough ___ No ___ Yes</p> <p>Spitting up blood ___ No ___ Yes</p> <p>Wheezing ___ No ___ Yes</p> <p><b>Skin</b></p> <p>Rash ___ No ___ Yes</p> <p>Itching ___ No ___ Yes</p>	<p><b>Gastrointestinal</b></p> <p>Poor appetite ___ No ___ Yes</p> <p>Difficulty swallowing ___ No ___ Yes</p> <p>Heartburn ___ No ___ Yes</p> <p>Nausea or Vomiting ___ No ___ Yes</p> <p>Bloating ___ No ___ Yes</p> <p>Belching ___ No ___ Yes</p> <p>Regurgitation ___ No ___ Yes</p> <p>Constipation ___ No ___ Yes</p> <p>Diarrhea ___ No ___ Yes</p> <p>Abdominal pain ___ No ___ Yes</p> <p>Recent change in bowel habits ___ No ___ Yes</p> <p>Rectal bleeding ___ No ___ Yes</p> <p>Black, tarry stools ___ No ___ Yes</p> <p><b>Neurological</b></p> <p>Headaches ___ No ___ Yes</p> <p>Seizures ___ No ___ Yes</p> <p>Strokes ___ No ___ Yes</p> <p>Numbness ___ No ___ Yes</p>	<p><b>Genitourinary</b></p> <p>Burning with urination ___ No ___ Yes</p> <p>Blood in urine ___ No ___ Yes</p> <p><b>Endocrine</b></p> <p>Heat/cold intolerance ___ No ___ Yes</p> <p>Excessive thirst/urination ___ No ___ Yes</p> <p><b>Musculoskeletal</b></p> <p>Joint pain or swelling ___ No ___ Yes</p> <p>Back pain ___ No ___ Yes</p> <p>Muscle pain ___ No ___ Yes</p> <p><b>Psychiatric</b></p> <p>Memory loss or confusion ___ No ___ Yes</p> <p>Depression ___ No ___ Yes</p> <p><b>Hematological</b></p> <p>Bleeding or bruising tendency ___ No ___ Yes</p> <p>Anemia ___ No ___ Yes</p> <p>Blood transfusion ___ No ___ Yes</p> <p>If so, what year? _____</p> <p>Are you pregnant? ___ No ___ Yes</p>
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**HEPATITIS SCREENING**

Have you ever had Hepatitis? ___ No ___ Yes	Do you have any of the following risk factors for Hepatitis? ___ No ___ Yes (Please check all that apply)
Have you ever been screened for Hepatitis? ___ No ___ Yes	<input type="checkbox"/> Injection drug use (even once) <input type="checkbox"/> Job exposure to blood/body fluids <input type="checkbox"/> Previous blood transfusion/organ transplant <input type="checkbox"/> Partner (s) with risk factors <input type="checkbox"/> Multiple sexual partners <input type="checkbox"/> Unsafe medical practices <input type="checkbox"/> Needle sticks <input type="checkbox"/> Tattoos/body piercings <input type="checkbox"/> Household member with Hepatitis <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Recreational cocaine use
Have you ever had yellow discoloration of the skin or eyes? ___ No ___ Yes	

**Office Use Only:** MD/NP Signature \_\_\_\_\_ Date \_\_\_\_\_

