753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Review of Systems

General

Please answer the following in reflection to how you currently feel since your last psychiatric visit.

Constitutional

- ☐ Fatigue
- ☐ Unexplained weight change
- ☐ Appetite Change
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Chills
- ☐ Prior diagnosis of cancer

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

HEENT

- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Bloody Nose
- ☐ Hoarseness/Voice Change
- ☐ Ear Infection History
- ☐ Ear Pain
- ☐ Sinus/Nasal Infection
- ☐ Facial/Sinus Surgery
- ☐ Tinnitus
- ☐ Decreased Hearing
- ☐ Decreased Vision
- ☐ Dry Mouth
- ☐ Facial Pain/Numbness
- ☐ Mouth Sores

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____

753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Skin and Nails

- ☐ Persistent Rash
- ☐ New Skin Lesion
- ☐ Skin Cancer History
- ☐ Hair Increase
- ☐ Hair Loss
- ☐ Change in Existing Lesion
- ☐ Changes in Nails
- ☐ Nail Pitting
- ☐ Bruising/Contusions
- ☐ Burns
- ☐ Cuts/Abrasions

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Cardiovascular System

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Tachycardia
- ☐ Bradycardia
- ☐ Irregular Heartbeat
- ☐ Swollen Ankles
- ☐ Shortness of Breath at Night
- ☐ Leg Cramps
- ☐ Phlebitis
- ☐ Hypertension
- ☐ CHF
- ☐ Fainting
- ☐ Paroxysmal Nocturnal Dyspnea
- ☐ Hx of Rheumatic Heart Disease
- ☐ Stress Test
- ☐ Echo
- ☐ Stents
- ☐ Cardiac Ablation

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____

753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Chest and Respiratory

- ☐ Shortness of Breath
- ☐ Prolonged Cough
- ☐ Asthma
- ☐ Pleurisy
- ☐ Chronic Bronchitis or Emphysema
- ☐ Bronchitis
- ☐ History of Pneumonia
- ☐ Long COVID Complications
- ☐ History of Tuberculosis
- ☐ Parasomnia
- ☐ Prior Sleep Study
- ☐ Nightmares or Night terrors
- ☐ History of OSA
- ☐ Use of CPAP/APAP/BiPAP
- ☐ Rib Pain
- ☐ Use of a Bite Block
- ☐ Oxygen/Condenser Use at Home
- ☐ Chest Wall/Thoracic Injury
- ☐ Breast Mass
- ☐ Breast Discharge

Last Breast Exam: _____

Last Mammogram: _____

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Unexpected Changes in Stool
- ☐ Black or Tarry Stools
- ☐ Blood in stools
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Jaundice
- ☐ History of Alcohol Abuse
- ☐ History of Hepatitis
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Peptic Ulcer Disease
- ☐ Gallbladder Disease
- ☐ Abdominal Surgery
- ☐ Pancreatitis
- ☐ History of GI Surgery
- ☐ GI Imaging

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____

753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Genitourinary

- ☐ Painful Urination
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Nocturnal Urination
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ STD/STI History
- ☐ Genital Lesions
- ☐ Decreased Libido
- ☐ Loss of Orgasms
- ☐ Renal Failure (Acute or Chronic)
- ☐ History of UTis
- ☐ Bladder Problems
- ☐ Pelvic Pain
- ☐ Sexual Dysfunction

Answer The Following If Applicable:

- ☐ Testicular Mass or Pain
- ☐ Erectile Dysfunction
- ☐ Impotence
- ☐ Prostate Problems
- ☐ Menopause
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Vaginal Pain

Pregnancy History:

Gravidity (# Pregnancies) ___

Term (# Pregnancies ≥37 weeks) ___

Preterm (# Pregnancies 20 to <37 weeks) ___

Abortion (# Losses before 20 weeks) ___

Living (# Living Children) ___

Menstrual Irregularities:

_____

_____

_____

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____

753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Musculoskeletal

- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ History of Fractures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Lyme Disease
- ☐ Orthopedic Surgeries
- ☐ Joint Deformities
- ☐ Back Pain
- ☐ Neck Pain

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Neurological

- ☐ Headaches
- ☐ Tension Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Trouble Walking or Off-Balance
- ☐ Tremors
- ☐ Changes in Sensation
- ☐ Uncontrolled Motions
- ☐ Double Vision
- ☐ Episodes of Vision Loss
- ☐ Sense of Spinning
- ☐ Gait Problems
- ☐ Falls
- ☐ Seizures
- ☐ Epilepsy
- ☐ TBI
- ☐ Concussion
- ☐ Head Injury
- ☐ Loss of Consciousness
- ☐ Cranial Surgery
- ☐ Spine Surgery
- ☐ Skull Fracture
- ☐ Focal Weakness
- ☐ Focal Sensory Change
- ☐ Chronic Pain
- ☐ Spine Injury
- ☐ Coma
- ☐ Encephalitis
- ☐ Stroke/TIA
- ☐ Chronic Fatigue Syndrome
- ☐ Brain Imaging
- ☐ EEGs

Other:

_____

_____

_____

❑ *Deny all symptoms otherwise not marked in the section above.*

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____

753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Endocrine and Hormone

- ☐ Thyroid Problems
- ☐ Intolerance to Heat or Cold
- ☐ Neck Irradiation History
- ☐ Frequent Hunger
- ☐ Frequent Urination
- ☐ Frequent Thirst

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

Hematologic

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Anemia
- ☐ Abnormal Blood Tests
- ☐ Unexplained swollen areas
- ☐ Leukemia
- ☐ Family History Disorder
- ☐ Swollen Lymph Nodes

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

Allergic and Immunologic

- ☐ Seasonal allergies
- ☐ Hay Fever
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Trouble with Itching
- ☐ Frequent Infections
- ☐ Exposure to HIV

Other:

_____

_____

_____

❑ Deny all symptoms otherwise not marked in the section above.

Patient Name: _____ Patient Birthdate: _____ Today's Date: _____