INTERVENTIONAL
PAIN ASSOCIATES (IPA)

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Name: _____ **DOB**: _____ **Date**: _____

REVIEW OF SYSTEMS:

List any problems you have or have had recently in the following areas. **CIRCLE THE SYMPTOMS YOU ARE HAVING.**

General Constitutional (fatigue, fever, unintentional weight gain, unintentional weight loss)	Yes	No
Head & Face (frequent headache, frequent face pain, drooping on one side of face)	Yes	No
Eyes (blurry vision, red eyes, sensitivity to light)	Yes	No
Neck (neck masses, pain in the neck, swollen glands)	Yes	No
Heart and Blood Vessels (blacking out or fainting, chest pain, irregular heart beat)	Yes	No
Lungs and respiratory system (shortness of breath, wheezing, and frequent productive cough)	Yes	No
Stomach and digestive (abdominal pain, frequent nausea, frequent vomiting)	Yes	No
Bones, Joints, or Muscles (cramping, pain in the back, painful joints, stiffness, and weakness)	Yes	No
Brain and Nervous System (change in alertness, seizures, loss of consciousness, tingling)	Yes	No
Mental and Emotional Health (trouble sleeping, anxiety, depression)	Yes	No
Endocrine (increased appetite, increased fatigue, increased thirst, enlarged neck)	Yes	No
Allergies, Infections, immune system (frequent infections, severe reaction to insect bite)	Yes	No