Name:_____DOB_____Date_____

Family Dr. / PCP_____

REVIEW OF SYSTEMS

*** PLEASE CIRCLE YES ONLY IF PROBLEM IS CURRENT***

CONSTITUTIONAL

Fever	Yes
Chills	Yes
Weight gain	Yes
Weight Loss	Yes
Fatigue	Yes
Loss of appetite	Yes

EYES

Double Vision	Yes
Glaucoma	Yes
Impaired Vision	Yes

HENT

Severe Headaches	Yes
Head injury	Yes
Ringing/Tinnitus in ears	Yes
Dizziness/Vertigo	Yes
Neck pain	Yes
Neck lumps	Yes
Lightheadedness	Yes
Sinus congestion	Yes
Dental problems	Yes
Thyroid mass/goiter	Yes
Sore Throat	Yes
Decreased hearing	Yes

BREASTS

Lumps	Yes
Nipple discharge	Yes
Do you self exam?	Yes
How Often?_____	
Ever had Mammogram	Yes
Tenderness	Yes
Redness	Yes

CARDIOVASCULAR

Chest pain	Yes
require 2-3 pillows to sleep	Yes
Irregular heart beats	Yes
rapid heart rate	Yes
syncope/fainting	Yes
shortness of breath on exertion	Yes
Lower extremity edema	Yes
Varicosities	Yes
Orthostatic symptoms	Yes

RESPIRATORY

Persistent cough	Yes
Blood tinged sputum	Yes
Shortness of Breath	Yes
History of TB	Yes
Wheezing	Yes

GASTROINTESTINAL

Nausea	Yes
Vomiting	Yes
Diarrhea	Yes
Blood in stools	Yes
Black, tarry stools	Yes
Constipation	Yes
Heartburn	Yes
Reflux	Yes
Abdominal Pain	Yes
Hemorrhoids	Yes
Fecal Incontinence	Yes

GENITOURINARY

Urgency	Yes
Frequency	Yes
Painful urination	Yes
Blood in urine	Yes
Leakage of urine w/activity	Yes
History of Venereal Disease	Yes
Heavy periods	Yes
Irregular periods	Yes
Painful cramps	Yes
Hot flashes	Yes
Vaginal dryness	Yes
Vaginal odor	Yes
Pain during intercourse	Yes
PMS	Yes
Night sweats	Yes
Vaginal discharge	Yes
Dysuria	Yes
Nocturia	Yes
Hematuria	Yes
Incontinence	Yes
Urinary retention	Yes
Decreased Libido	Yes
Genital Sores	Yes
Post-coital bleeding	Yes
Amenorrhea	Yes
Difficulty Voiding	Yes

INTEGUMENT

Rash	Yes
Itching	Yes
New skin lesions	Yes
Hirsutism	Yes
Acne	Yes

NEUROLOGIC

Seizures	Yes
Paralysis	Yes
Tremors	Yes
Fainting/Blackouts	Yes
Tingling/Numbness	Yes
Memory difficulties	Yes
Loss of balance	Yes
Snoring	Yes

MUSCULOSKELETAL

Joint Pain	Yes
Joint Swelling	Yes
Muscle pain/Cramps	Yes
Back pain	Yes
Hip pain	Yes

ENDOCRINE

Heat Intolerance	Yes
Cold Intolerance	Yes
Excessive hunger	Yes
Polydipsia	Yes
Loss of Hair	Yes
Diabetes	Yes

PSYCHIATRIC

Depression	Yes
Anxiety	Yes
Difficulty Sleeping	Yes

HEME-LYMPH

Easy bruising	Yes
Easy bleeding	Yes
Past blood Transfusion	Yes
Lightheadedness	Yes
Enlarged or Tender Lymph Node	Yes