

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Family Dr. / PCP \_\_\_\_\_

## REVIEW OF SYSTEMS

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

<b>CONSTITUTIONAL</b>		<b>RESPIRATORY</b>		<b>INTEGUMENT</b>	
Fever	Yes	Persistent cough	Yes	Rash	Yes
Chills	Yes	Blood tinged sputum	Yes	Itching	Yes
Weight gain	Yes	Shortness of Breath	Yes	New skin lesions	Yes
Weight Loss	Yes	History of TB	Yes	Hirsutism	Yes
Fatigue	Yes	Wheezing	Yes	Acne	Yes
Loss of appetite	Yes				
<b>EYES</b>		<b>GASTROINTESTINAL</b>		<b>NEUROLOGIC</b>	
Double Vision	Yes	Nausea	Yes	Seizures	Yes
Glaucoma	Yes	Vomiting	Yes	Paralysis	Yes
Impaired Vision	Yes	Diarrhea	Yes	Tremors	Yes
		Blood in stools	Yes	Fainting/Blackouts	Yes
<b>HENT</b>		Black, tarry stools	Yes	Tingling/Numbness	Yes
Severe Headaches	Yes	Constipation	Yes	Memory difficulties	Yes
Head injury	Yes	Heartburn	Yes	Loss of balance	Yes
ringing/Tinnitus in ears	Yes	Reflux	Yes	Snoring	Yes
Dizziness/Vertigo	Yes	Abdominal Pain	Yes		
Neck pain	Yes	Hemorrhoids	Yes		
Neck lumps	Yes	Fecal Incontinence	Yes		
Lightheadedness	Yes			<b>MUSCULOSKELETAL</b>	
Sinus congestion	Yes	<b>GENITOURINARY</b>		Joint Pain	Yes
Dental problems	Yes	Urgency	Yes	Joint Swelling	Yes
Thyroid mass/goiter	Yes	Frequency	Yes	Muscle pain/Cramps	Yes
Sore Throat	Yes	Painful urination	Yes	Back pain	Yes
Decreased hearing	Yes	Blood in urine	Yes	Hip pain	Yes
		Leakage of urine w/activity	Yes		
<b>BREASTS</b>		History of Venereal Disease	Yes	<b>ENDOCRINE</b>	
Lumps	Yes	Heavy periods	Yes	Heat Intolerance	Yes
Nipple discharge	Yes	Irregular periods	Yes	Cold Intolerance	Yes
Do you self exam?	Yes	Painful cramps	Yes	Excessive hunger	Yes
How Often? _____		Hot flashes	Yes	Polydipsia	Yes
Ever had Mammogram	Yes	Vaginal dryness	Yes	Loss of Hair	Yes
Tenderness	Yes	Vaginal odor	Yes	Diabetes	Yes
Redness	Yes	Pain during intercourse	Yes		
		PMS	Yes	<b>PSYCHIATRIC</b>	
<b>CARDIOVASCULAR</b>		Night sweats	Yes	Depression	Yes
Chest pain	Yes	Vaginal discharge	Yes	Anxiety	Yes
require 2-3 pillows to sleep	Yes	Dysuria	Yes	Difficulty Sleeping	Yes
Irregular heart beats	Yes	Nocturia	Yes		
rapid heart rate	Yes	Hematuria	Yes	<b>HEME-LYMPH</b>	
syncope/fainting	Yes	Incontinence	Yes	Easy bruising	Yes
shortness of breath on exertion	Yes	Urinary retention	Yes	Easy bleeding	Yes
Lower extremity edema	Yes	Decreased Libido	Yes	Past blood Transfusion	Yes
Varicosities	Yes	Genital Sores	Yes	Lightheadedness	Yes
Orthostatic symptoms	Yes	Post-coital bleeding	Yes	Enlarged or Tender Lymph Node	Yes
		Amenorrhea	Yes		
		Difficulty Voiding	Yes		