

Review of Systems

CONSTITUTIONAL

Weight Loss/Gain YES NO
 Fatigue YES NO
 Fever YES NO
 Sweats YES NO

EYES

Glasses/Contacts YES NO
 Pain YES NO
 Double Vision YES NO
 Blind Spots YES NO
 Blind YES NO
 Cataracts YES NO
 Glaucoma YES NO

EAR/NOSE/THROAT

Hearing Loss YES NO
 Ringing in Ears YES NO
 Ear Pain YES NO
 Vertigo YES NO
 Nasal Stuffiness YES NO
 Sinus Trouble YES NO
 Sore Throats YES NO
 Difficulty Swallowing YES NO
 Hoarseness YES NO

CARDIOVASCULAR

Chest Pain YES NO
 Heart Attack YES NO
 Palpitations YES NO
 Murmur YES NO
 High Blood Pressure YES NO
 Dizziness YES NO
 Fainting Spells YES NO
 Difficulty Lying Flat YES NO
 Swollen Ankles YES NO

HEME/LYMPH

Easy Bleeding/Bruising YES NO
 Bleeding Gums YES NO
 Enlarged Glands YES NO
 Blood Transfusion YES NO

GASTROINTESTINAL

Nausea/Vomiting YES NO
 Difficulty Swallowing YES NO
 Abdominal Pain YES NO
 Jaundice YES NO
 Diarrhea YES NO
 Constipation YES NO
 Change in BM's YES NO
 Pain with BM's YES NO
 Rectal Bleeding YES NO
 Regurgitation YES NO
 Heartburn or Indigestion YES NO
 Trouble with Spicy Foods YES NO
 Burning stomach YES NO
 Hemorrhoids YES NO
 Ever had Hepatitis YES NO
 Black, Tarry Stools YES NO
 Ulcer Problems YES NO
 Food get stuck in your chest when you swallow YES NO

GENITOURINARY

Urgency YES NO
 Frequency YES NO
 Night time-Frequency YES NO
 Burning YES NO
 Blood in Urine YES NO
 Decreased Stream YES NO
 Kidney Stones YES NO
 Sexually Transmitted Disease YES NO
 Abnormal Discharge YES NO
 Leaking Urine YES NO

MUSCULOSKELETAL

Joint Pain/Swelling YES NO
 Muscle Pain YES NO
 Neck/Back Pain YES NO
 Gout YES NO
 Varicose Veins YES NO

NEUROLOGICAL

Headaches YES NO
 Seizures YES NO
 Tremors YES NO
 Weakness/Paralysis YES NO
 Numbness/Tingling YES NO
 Speech Difficulty YES NO
 Memory Loss YES NO
 Stroke YES NO

ENDOCRINE

Hair Loss YES NO
 Heat/Cold Intolerance YES NO
 Change in Nails YES NO
 Thyroid Problems YES NO
 Diabetes YES NO
 Blood Sugar Problems YES NO

PSYCHIATRIC

Anxiety/Depression YES NO
 Mood Swings YES NO
 Difficulty Sleeping YES NO

RESPIRATORY

Chronic Cough YES NO
 Cough Blood YES NO
 Shortness of Breath YES NO
 at Rest YES NO
 with Exertion YES NO
 Asthma/Emphysema YES NO

SKIN

Rash/Sores YES NO
 Lesions YES NO
 Itching/Burning YES NO

ALLERGIC/IMMUNE

Hay Fever YES NO
 Eczema/Hives YES NO

BREASTS

Lumps in breasts YES NO
 Had surgery on breasts YES NO
 Have bloody discharge YES NO
 Had skin dimpling YES NO
 Date of last mammogram _____
 Where was it taken _____

GYN (Women Only)

of pregnancies: _____
 # of children: _____
 # of abortions: _____
 # of miscarriages: _____

Reviewed by: _____

Date: _____