REVIEW OF SYSTEMS

PATIENT NAME:_____

DATE OF BIRTH:_____

CONSTITUTIONAL

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses/ contact lenses	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

ENT

Hearing loss	YES	NO
Ringing in ears	YES	NO
Earaches or drainage	YES	NO
Sinus problems	YES	NO
Nose Bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pains	YES	NO
Sudden heart beat changes	YES	NO
Swelling of feet or hands	YES	NO

RESPIRATORY

Frequent coughing	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or Vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements or constipation	YES	NO
Blood in stool	YES	NO
Stomach pain	YES	NO

GENITOURINARY

Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force of strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Male- testicular pain	YES	NO
Female- pain w/ periods	YES	NO
Female- irregular periods	YES	NO
Female- vaginal discharge	YES	NO

Female- # of pregnancies___
# of miscarriages___
Female- date of last pap smear _____
Female- findings of last pap smear __normal
__abnormal

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty in walking	YES	NO

SKIN

Rash or itching	YES	NO
Change in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

NEUROLOGICAL

Frequent or reccurring headaches	YES	NO
Light headed or dizzy	YES	NO
Convulsions or seizures	YES	NO
Numbness or tingling sensations	YES	NO
Tremors	YES	NO
Paralysis	YES	NO
Stroke	YES	NO

PSYCHIATIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Sleep problems	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Dry skin	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGIC/ LYMPHATIC

Slow to heal after cuts	YES	NO
Easily bruise or bleed	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusion	YES	NO
Enlarged glands	YES	NO

SIGNATURE:_____

DATE:_____

REVIEW OF SYSTEMS