

Review of Systems

Please, print your name!

Do you have or have you had in the recent past any of the following:

Constitutional:

- Recent weight change
of more than 10 pounds YES NO
- Worry or preoccupation with weight YES NO
- Decreased appetite YES NO
- Frequent fevers/nightsweats YES NO
- Fatigue or weakness YES NO
- Difficulties sleeping YES NO
- Special diet YES NO

Eyes:

- Wear glasses or contact lenses YES NO
- Blurred or double vision YES NO
- Burning / itching / watery eyes YES NO
- Pain or redness YES NO

Ears Nose and Throat:

- Difficulty hearing YES NO
- Nose bleeds YES NO
- Chronic or recurrent sore throat YES NO
- Mouth sores YES NO
- Hoarseness YES NO
- Dental problems YES NO

Respiratory:

- Chronic or frequent coughs YES NO
- Shortness of breath YES NO
- Coughing up blood YES NO
- Wheezing YES NO
- Snoring YES NO

Cardiovascular:

- Palpitations YES NO
- Chest pain or tightness YES NO
- Fainting YES NO
- Swelling of feet or legs YES NO
- Irregular heart beat YES NO
- Heart murmur YES NO
- Unable to climb 2 flights of stairs YES NO

Gastrointestinal:

- Black or bloody stools YES NO
- Hemorrhoids YES NO
- Nausea or vomiting YES NO
- Diarrhea YES NO
- Constipation or use of laxatives YES NO
- Change in bowel habits YES NO
- Abdominal pain or heartburn YES NO

Genitourinary:

- Frequent urination YES NO
- Urinating more than once at night YES NO
- Burning pain on urination YES NO
- Blood in urine YES NO
- Difficulty holding urine YES NO
- Sexual dysfunctions YES NO

Endocrine:

- Goiter now or in The past YES NO
- Bothered excessively by
hot or cold weather YES NO
- Excessive sweating YES NO
- Thirsty most of the time YES NO
- High blood sugar YES NO

Hematologic/Lymphatic:

- Bleeding or bruising easily YES NO
- Lumps in neck, armpits, groin YES NO
- Low blood count in the past YES NO

Allergic/Immunologic:

- Recurrent infections YES NO
- Allergies or hay fever YES NO

Neurological:

- Frequent or Chronic headache YES NO
- Muscle weakness YES NO
- Convulsions or seizures YES NO
- Memory problems YES NO
- History of mini strokes YES NO

Psychiatric:

- Hospitalized for mental
or nervous disorder YES NO
- Depressed or sad YES NO
- Nervous or anxious YES NO
- Excessive stress YES NO
- Sleep problems YES NO
- Attempted suicide YES NO

Musculoskeletal:

- Painful or swollen joints YES NO
- Trouble with your back YES NO
- Difficulty or pain with walking YES NO

Skin:

- Rashes or itching YES NO
- Change in skin color YES NO

Women:

- Vaginal bleeding between
periods or after Intercourse YES NO
- Vaginal discharge or lesions YES NO
- Discharge or lump in breast YES NO

Men:

- Discharge or drip from penis YES NO
- Sore or lump near or on penis YES NO
- Lump on testicles YES NO

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____