

**Review of Systems**  
(please circle your answer)

**-CONSTITUTIONAL SYMPTOMS**

Good general health lately \_\_\_\_\_ no....yes  
Recent weight change \_\_\_\_\_ no....yes  
Fever \_\_\_\_\_ no....yes  
Fatigue \_\_\_\_\_ no....yes  
Headaches \_\_\_\_\_ no....yes

**-EYES**

Eye disease \_\_\_\_\_ no....yes  
Wear glasses/contact lens \_\_\_\_\_ no....yes  
Blurred or double vision \_\_\_\_\_ no....yes  
Glaucoma \_\_\_\_\_ no....yes

**-EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing \_\_\_\_\_ no....yes  
Earaches or drainage \_\_\_\_\_ no....yes  
Chronic sinus problem or rhinitis \_\_\_\_\_ no....yes  
Nose bleeds \_\_\_\_\_ no....yes  
Mouth sores \_\_\_\_\_ no....yes  
Bad Breath or bad taste \_\_\_\_\_ no....yes  
Sore throat or voice change \_\_\_\_\_ no....yes  
Swollen glands in neck \_\_\_\_\_ no....yes

**-CARDIOVASCULAR**

Heart trouble \_\_\_\_\_ no....yes  
Chest pain or angina pectoris \_\_\_\_\_ no....yes  
Palpitation \_\_\_\_\_ no....yes  
Shortness of breath w/walking or lying flat \_\_\_\_\_ no....yes  
Swelling in feet, ankles or hands \_\_\_\_\_ no....yes

**-RESPIRATORY**

Chronic or frequent coughs \_\_\_\_\_ no....yes  
Spitting up blood \_\_\_\_\_ no....yes  
Shortness of breath \_\_\_\_\_ no....yes  
Asthma or wheezing \_\_\_\_\_ no....yes

**-GASTROINTESTINAL**

Loss of appetite \_\_\_\_\_ no....yes  
Change in bowel movements \_\_\_\_\_ no....yes  
Nausea or vomiting \_\_\_\_\_ no....yes  
Frequent diarrhea \_\_\_\_\_ no....yes  
Painful bowel movements or constipation \_\_\_\_\_ no....yes  
Rectal bleeding or blood in stool \_\_\_\_\_ no....yes

**-GASTROINTESTINAL (cont.)**

Abdominal pain or heartburn \_\_\_\_\_ no....yes  
Peptic ulcer (stomach or duodenal) \_\_\_\_\_ no....yes

**-GENITOURINARY**

Frequent urination \_\_\_\_\_ no....yes  
Burning or painful urination \_\_\_\_\_ no....yes  
Blood or painful urination \_\_\_\_\_ no....yes  
Change in force of strain when urinating \_\_\_\_\_ no....yes  
Incontinence or dribbling \_\_\_\_\_ no....yes  
Kidney stones \_\_\_\_\_ no....yes  
Sexual difficulty \_\_\_\_\_ no....yes  
Male-testicle pain \_\_\_\_\_ no....yes  
Female- date of last pap smear \_\_\_\_\_ no....yes

**-MUSCULOSKELETAL**

Joint pain \_\_\_\_\_ no....yes  
Joint stiffness or swelling \_\_\_\_\_ no....yes  
Weakness of muscles or joints \_\_\_\_\_ no....yes  
Muscle pain of cramps \_\_\_\_\_ no....yes  
Back pain \_\_\_\_\_ no....yes  
Cold extremities \_\_\_\_\_ no....yes  
Difficulty in walking \_\_\_\_\_ no....yes

**-INTEGUMENTARY (skin, breast)**

Rash or itching \_\_\_\_\_ no....yes  
Change in hair, nails or skin color \_\_\_\_\_ no....yes  
Varicose veins \_\_\_\_\_ no....yes  
Breast pain \_\_\_\_\_ no....yes  
Breast lump \_\_\_\_\_ no....yes  
Breast Discharge \_\_\_\_\_ no....yes

**-NEUROLOGICAL**

Frequent or recurring headaches \_\_\_\_\_ no....yes  
Light headed or dizzy \_\_\_\_\_ no....yes  
Convulsions or seizures \_\_\_\_\_ no....yes  
Numbness or tingling sensations \_\_\_\_\_ no....yes  
Tremors \_\_\_\_\_ no....yes  
Paralysis \_\_\_\_\_ no....yes  
Stroke \_\_\_\_\_ no....yes  
Head injury \_\_\_\_\_ no....yes

**-PSYCHIATRIC**

Memory loss or confusion \_\_\_\_\_ no....yes  
Nervousness \_\_\_\_\_ no....yes  
Depression \_\_\_\_\_ no....yes

Insomnia \_\_\_\_\_ no....yes

**-ENDOCRINE**

Glandular or hormone problem \_\_\_\_\_ no....yes

Thyroid disease \_\_\_\_\_ no....yes

Diabetes \_\_\_\_\_ no....yes

Excessive thirst or urination \_\_\_\_\_ no....yes

Heat or cold intolerance \_\_\_\_\_ no....yes

Skin becoming dryer \_\_\_\_\_ no....yes

Change in hand or glove size \_\_\_\_\_ no....yes

**-HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts \_\_\_\_\_ no....yes

Bleeding or bruising tendency \_\_\_\_\_ no....yes

Anemia \_\_\_\_\_ no....yes

Phlebitis \_\_\_\_\_ no....yes

Past transfusion \_\_\_\_\_ no....yes

Enlarged glands \_\_\_\_\_ no....yes

**-ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics \_\_\_\_\_ no....yes

Morphine, Demerol, or other narcotics \_\_\_\_\_ no....yes

Novocain or other anesthetics \_\_\_\_\_ no....yes

Aspirin or other pain remedies \_\_\_\_\_ no....yes

Tetanus antitoxin or other serums \_\_\_\_\_ no....yes

Iodine, methiolate or other antiseptic \_\_\_\_\_ no....yes

Other allergies: food or medications \_\_\_\_\_ no....yes

Name \_\_\_\_\_