

Review of Systems

Patient Name: _____ Date _____/_____/_____

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**

<p>Constitutional Symptoms</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Fever</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Chills</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Headache</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Fever	Y	N	Chills	Y	N	Headache	Y	N	Other _____			<p>Integumentary</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Skin rash</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Boils</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Persistent itch</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Skin rash	Y	N	Boils	Y	N	Persistent itch	Y	N	Other _____		
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<p>Eyes</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Blurred Vision</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Double Vision</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Pain</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Blurred Vision	Y	N	Double Vision	Y	N	Pain	Y	N	Other _____			<p>Musculoskeletal</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Joint pain</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Neck pain</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Back pain</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Joint pain	Y	N	Neck pain	Y	N	Back pain	Y	N	Other _____		
Blurred Vision	Y	N																							
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<p>Allergic/Immunologic</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Hay Fever</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Drug Allergies</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Hay Fever	Y	N	Drug Allergies	Y	N	Other _____			<p>Ear/ Nose/ Throat/ Mouth</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Ear Infection</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Sore throat</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Sinus problem</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Ear Infection	Y	N	Sore throat	Y	N	Sinus problem	Y	N	Other _____					
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<p>Neurological</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Tremors</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Dizzy spells</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Numbness/tingling</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Tremors	Y	N	Dizzy spells	Y	N	Numbness/tingling	Y	N	Other _____			<p>Genitourinary</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Urine retention</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Painful urination</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Urinary frequency</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Urine retention	Y	N	Painful urination	Y	N	Urinary frequency	Y	N	Other _____		
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<p>Endocrine</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Excessive thirst</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Too hot/cold</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Tired/sluggish</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Excessive thirst	Y	N	Too hot/cold	Y	N	Tired/sluggish	Y	N	Other _____			<p>Respiratory</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Wheezing</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Frequent cough</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Shortness of breath</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Wheezing	Y	N	Frequent cough	Y	N	Shortness of breath	Y	N	Other _____		
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<p>Gastrointestinal</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Abdominal pain</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Nausea/vomiting</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Indigestion/heartburn</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Abdominal pain	Y	N	Nausea/vomiting	Y	N	Indigestion/heartburn	Y	N	Other _____			<p>Hematologic/Lymphatic</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Swollen glands</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Blood clotting problem</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Swollen glands	Y	N	Blood clotting problem	Y	N	Other _____					
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<p>Cardiovascular</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Chest pain</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Varicose veins</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>High blood pressure</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> </tr> </table>	Chest pain	Y	N	Varicose veins	Y	N	High blood pressure	Y	N	Other _____			<p>Psychologic</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Are you generally satisfied with your life?</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Do you feel severely depressed?</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Have you considered suicide?</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> </table>	Are you generally satisfied with your life?	Y	N	Do you feel severely depressed?	Y	N	Have you considered suicide?	Y	N			
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Are you generally satisfied with your life?	Y	N																							
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<p>Last Eye & Dental Exam</p> <p>Date – Last Eye Exam: _____/_____/_____</p> <p>Date – Last Dental Exam _____/_____/_____</p>	<p>Sexual History</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Change in sex drive?</td> <td style="width: 10%; text-align: center;">Y</td> <td style="width: 20%; text-align: center;">N</td> </tr> <tr> <td>Sexual performance satisfactory?</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>Other (i.e. sexual trauma) _____</td> <td></td> <td></td> </tr> </table>	Change in sex drive?	Y	N	Sexual performance satisfactory?	Y	N	Other (i.e. sexual trauma) _____																	
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Physician use only: (Comments/Notes)

Physician/Provider Signature: _____ Date: _____