

"Review of Systems"-To be completed by the patient.

		Current Health Problem	Explanation
YES	NO	CONSTITUTIONAL	
		Elevated Blood Pressure	
		Change in energy	
		Change in weight	
		Fever, chills or sweats	

YES	NO	HEENT	
		Problems with eyes, ears, nose, mouth, or throat	
		Double vision, blurry vision, temporary loss of vision	
		Difficulty swallowing	

YES	NO	CARDIOVASCULAR SYSTEM	
		History of heart attack, angina, chest pain	
		Rapid or slowed pulse	
		Cold extremities, claudication (pain in legs when walking)	

YES	NO	RESPIRATORY SYSTEM	
		Bronchitis, asthma, shortness of breath	
		Tuberculosis	
		Pneumonia	
		Wheezing	
		Frequent cough	
		Coughing up blood	
		Productive cough	

YES	NO	GASTROINTESTINAL SYSTEM	
		Nutrition or dietary problems	
		Change in appetite (increased or decreased)	
		Recent weight loss or weight gain	
		GERD (stomach reflux disease)	
		Peptic ulcers, bleeding ulcers	
		Nausea, vomiting, blood when vomiting	
		Diarrhea/Constipation/Loss of stools, incontinence	
		Blood in stools or black tarry stools	

YES	NO	GENITOURINARY SYSTEM	
		Loss of urine, incontinence, urgency	
		Difficulty starting to urinate/Pain with urination	
		Blood in the urine	
		Issues related to sexual intercourse, libido	
		Impotence (Sexual dysfunction)	
		For Women: Problems/Changes with menstruation	
		History of venereal disease, herpes	
		Up to urinate more than once during the night	

YES	NO	INTEGUMENTARY/SKIN/INFECTION	
		Skin problems: wounds, scars, excessive perspiration	
		Excessive itchiness of the skin	
		MRSA (methicillin resistant Staphylococcus aureus)	

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YES	NO	MUSCULOSKELETAL	
		Neck pain, recent injury	
		Back pain, recent injury	
		Weakness of arms, dropping items	
		Weakness of legs, legs "giving out"	
		Uncontrolled muscle movements	
		Night cramps	
		Muscle Aches/Pain, Swelling or Stiffness	
		Arthritis	
		History of Fractures	
		Change in temperature of extremities, swelling	

YES	NO	NERVOUS SYSTEM	
		History of Stroke or TIA ("mini stroke")	
		Frequent headaches: migraines, sinus headaches	
		Seizure disorder (convulsions, fits)	
		Mental status: confusion, fatigue, memory loss	
		Loss of Balance, problems with coordination	
		Feeling of numbness or "pins and needles"	
		Disturbance of taste/smell, hearing	
		Focal weakness, a muscle "not working right"	

YES	NO	HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC	
		History of blood clots	
		Blood thinners: Coumadin, Plavix, Aspirin	
		Liver problems: hepatitis, cirrhosis, jaundice	
		Anemia	
		History of bleeding (w/ minor injury) or bruising easily	
		Fever, chills, night sweats	

YES	NO	ENDOCRINE	
		Diabetes or excessive thirst, frequent urination	
		Thyroid problems	
		Hot or cold intolerance	

YES	NO	PSYCHIATRIC HISTORY	
		Depression, tearfulness, hopelessness/Mood swings	
		Feeling suicidal or past suicide attempts	
		Sleep disturbances, insomnia	

YES	NO	SOCIAL HISTORY	
		Use of tobacco: smoke cigarettes, cigar, chew	
		Alcohol Use (list usage in right hand column)	
		Use of recreational or street drugs	
		Caffeine use (coffee, tea, pop, Excedrin)	
		Living Will	

YES	NO	ALLERGIES/INTOLERANCES	
		Environmental allergies, hay fever, ragweed, dust, etc.	
		Any allergies to Medications or Foods-LIST ALL	