Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General** |  |  | **Ear/ Nose/ Mouth** |  |  |
| Have you had fever, chills, or sweats? | Y | N | Ear pain | Y | N |
| Have you gained or lost weight recently? | Y | N | Sore throat/hoarse | Y | N |
| How many pounds? | \_\_\_\_\_\_\_ | | Sinus problem | Y | N | |  |
| Other |  |  | Other |  |  |
|  |  |  |  |  |  |
| **Eyes** |  |  | **Genitourinary** |  |  |
| Blurred vision | Y | N | Blood in the urine | Y | N |
| Double vision | Y | N | Painful/ Frequent Urination | Y | N |
| Have you ever lost vision? | Y | N | Irregular menstruation | Y | N |
| Other |  |  | Vaginal discharge/Itching | Y | N |
|  |  |  | Pain during/after sex | Y | N |
|  |  |  | Other |  |  |
|  |  |  |  |  |  |
| **Allergic/Immunologic** |  |  | **Respiratory** |  |  |
| Hay Fever | Y | N | Asthma | Y | N |
| Drug Allergies | Y | N | Frequent cough | Y | N |
| infections | Y | N | Shortness of breath | Y | N |
| Other |  |  | Other |  |  |
|  |  |  |  |  |  |
| **Neurological** |  |  | **Hematologic/Lymphatic** |  |  |
| Seizures | Y | N | Anemia | Y | N |
| Trouble sleeping | Y | N | Swollen glands | Y | N |
| Headaches | Y | N | Blood clotting problem | Y | N |
| Other |  |  | Other |  |  |
|  |  |  |  |  |  |
| **Endocrine** |  |  | **Psychiatric** |  |  |
| Excessive thirst | Y | N | Are you unhappy with your life? | Y | N |
| Too hot/cold | Y | N | Do you feel severely depressed? | Y | N |
| Tired/sluggish | Y | N | Have you considered suicide? | Y | N |
| Other |  |  | Other |  |  |
| **Gastrointestinal** |  |  | **Musculoskeletal** |  |  |
| Abdominal pain | Y | N | Joint pain | Y | N |
| Nausea/vomiting | Y | N | Swelling in your joints | Y | N |
| Diarrhea | Y | N | Arthritis | Y | N |
| Other |  |  | Other |  |  |
|  |  |  |  |  |  |
| **Cardiovascular** |  |  | **Integumentary** |  |  |
| Chest pain | Y | N | Skin rash | Y | N |
| Palpitations | Y | N | Nipple discharge | Y | N |
| High blood pressure | Y | N | Persistent itch | Y | N |
| Other |  |  | Other |  |  |
|  | | | | | |

**Physician Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. ( )**