

Review of Systems Form

Patient's Name _____ **Date Completed** _____

<u>Constitutional Symptoms</u>	<u>Yes</u>	<u>No</u>	<u>Gastrointestinal</u>	<u>Yes</u>	<u>No</u>	<u>Psychiatric</u>	<u>Yes</u>	<u>No</u>
Fatigue	___	___	Loss of appetite	___	___	Alzheimer's Disease	___	___
Recent weight loss/gain	___	___	Nausea/Vomiting	___	___	Memory loss/confusion	___	___
Recurring fever	___	___	Frequent diarrhea	___	___	Depression	___	___
<u>Eyes</u>			Constipation	___	___	Suicidal thoughts	___	___
Eye Disease or injury	___	___	Rectal bleeding	___	___	Chemical dependency	___	___
Wear glasses/contacts	___	___	Abdominal pain	___	___	<u>Neurological</u>		
Blurred/double vision	___	___	Stomach ulcer/heartburn	___	___	Frequent/recurring headaches	___	___
Glaucoma	___	___	Hepatitis	___	___	Migraines	___	___
<u>Ear, Nose, Mouth, Throat</u>			Cirrhosis	___	___	Light-headed/dizzy	___	___
Hearing loss or ringing	___	___	Pancreatitis	___	___	Convulsions/seizures	___	___
Ear infections/drainage	___	___	<u>Genitourinary</u>			Numbness or tingling	___	___
Chronic sinus problems	___	___	Renal (Kidney) Disease	___	___	Paralysis	___	___
Nosebleeds	___	___	Frequent urination	___	___	Stroke	___	___
Mouth sores	___	___	Burning or painful urination	___	___	Head injury	___	___
Bleeding gums	___	___	Blood in urine	___	___	Polio	___	___
Hoarseness	___	___	Sexually transmitted disease	___	___	Multiple sclerosis	___	___
Swollen glands in neck	___	___	Prostate disease	___	___	Cerebral Palsy	___	___
<u>Cardiovascular</u>			<u>Musculoskeletal</u>			<u>Endocrine</u>		
Chest pain	___	___	Arthritis, degenerative	___	___	<u>Diabetes</u>		
Heart attack	___	___	Arthritis, rheumatoid	___	___	If Diabetic, Average blood sugar	___	___
Palpitations	___	___	Joint pain	___	___			
Swelling of feet, hands, ankles	___	___	Weakness of muscle/joints	___	___	Insulin Dependent?	___	___
Rheumatic fever	___	___	Muscle pain or cramps	___	___	Non-Insulin Dependent?	___	___
Heart valve replacement	___	___	Back pain	___	___	Diet Controlled?	___	___
High blood pressure	___	___	Cold extremities	___	___	Thyroid disease	___	___
Low blood pressure	___	___	Difficulty walking	___	___	Glandular/hormonal prob.	___	___
Mitral valve prolapse	___	___	Muscular dystrophy	___	___	Excessive thirst or urination	___	___
Heart Murmur	___	___	Osteoporosis	___	___	<u>Hematologic/lymphatic</u>		
High cholesterol	___	___	Joint replacement	___	___	Slow to heal after cuts	___	___
Pacemaker	___	___	Fibromyalgia	___	___	Bleeding or bruising	___	___
<u>Respiratory</u>			<u>Skin</u>			Anemia	___	___
Chronic or frequent cough	___	___	Rash/itching	___	___	Phlebitis/blood clots	___	___
Spitting up blood	___	___	Change in skin color	___	___	Past transfusions	___	___
Shortness of breath	___	___	Change in hair	___	___	Leukemia	___	___
Asthma or wheezing	___	___	Hives	___	___	Lymphoma	___	___
Tuberculosis	___	___	Psoriasis	___	___	HIV/AIDS	___	___
Emphysema	___	___	<u>Other</u>			Sickle cell	___	___
Pulmonary Disease	___	___	_____			Cancer	___	___
Sleep Apnea	___	___	_____			Radiation Treatment	___	___
If yes, use a breathing machine	___	___	_____					
Use Home Oxygen	___	___	_____					

X _____
Patient/Legal Representative/Parent Signature **Date** Physician's Signature **Date**

For Office Use Only:

_____ Physician's Signature **Date**

_____ Physician's Signature **Date**