

# REVIEW OF SYSTEMS

Name: \_\_\_\_\_

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

## REVIEW OF SYSTEMS

(Please check if you have/had problems related to the areas indicated below.)

	YES	NO		YES	NO
<b>1. CONSTITUTIONAL</b>			<b>7. ENDOCRINE SYSTEM</b>		
Weight loss or gain (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem (hypo/hyper)	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hormone treatment	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. EYES</b>			<b>8. BREAST/GENITAL</b>		
Vision surgery	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Malignant or benign mass	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Genital Infections	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. EARS, NOSE, THROAT</b>			<b>9. URINARY SYSTEM</b>		
Nose/gum bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. RESPIRATORY</b>			Stress Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Uncontrolled/difficult urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<b>10. SKIN</b>		
Bronchitis/pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Cancers (cause)_____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Rashes(cause)_____	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. CARDIOVASCULAR</b>			<b>11. NEUROLOGIC</b>		
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Recent chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<b>12. PSYCHIATRIC</b>		
Previous Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Transfusions/Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Any other history	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems/clots	<input type="checkbox"/>	<input type="checkbox"/>	<b>13. MUSCULOSKELETAL</b>		
<b>6. GASTROINTESTINAL</b>			Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>	<b>OTHER:</b> _____		
Abdominal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	_____		

If you answered yes to any of the above questions, please clarify (use back page if necessary)

Medical Issue	Date of Onset	Treatment/Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information provided in this form is true and complete to the best of my knowledge.

Patient Signature \_\_\_\_\_

Form reviewed by physician: \_\_\_\_\_ DATE: \_\_\_\_\_