



REVIEW OF SYSTEMS

1. **Constitutional Symptoms**

General Good Health	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headache	No	Yes

2. **Skin**

Rash	No	Yes
Unusual Lesions	No	Yes

3. **Eyes**

Blurred Vision	No	Yes
Eye Pain	No	Yes
Glasses/Contacts	No	Yes

4. **Ears, Nose, Throat**

Sinus Congestion	No	Yes
Sore Throat	No	Yes
Ringing in ear(s)	No	Yes
Hard of hearing	No	Yes

5. **Respiratory**

Shortness of breath	No	Yes
Chronic/Frequent Cough	No	Yes
Wheezing	No	Yes
Coughing up blood	No	Yes

6. **Cardiovascular**

Chest Pain	No	Yes
Chest Pain with exertion	No	Yes
Murmur	No	Yes
Swelling of hands or feet	No	Yes

7. **Gastrointestinal**

Abdominal Pain	No	Yes
Nausea/Vomiting	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Heartburn	No	Yes
Loss of bowel control	No	Yes

8. **Genitourinary**

# times void at night _____		
Painful Urination	No	Yes
Blood in urine	No	Yes
Frequent Urination	No	Yes
Urgency to urinate	No	Yes
Difficulty starting stream	No	Yes
Slow stream	No	Yes

Genitourinary Cont.

Start/stop stream	No	Yes
Feeling that bladder is not emptying	No	Yes
Straining to void	No	Yes
After void dribbling	No	Yes

Leakage of urine:		
with coughing	No	Yes
with urgency	No	Yes
# of pads used daily _____		

Pain with intercourse	No	Yes
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Male:

Testicle Pain	No	Yes
Erectile Dysfunction	No	Yes
Testicle Mass/Lump	No	Yes

Female:

# of pregnancies _____	# of deliveries _____
# of miscarriages _____	# of abortions _____
Date of last menstrual period: _____	
Date of last pap smear: _____	
Results: _____	

9. **Musculoskeletal**

Back Pain	No	Yes
Neck Pain	No	Yes
Back Injury	No	Yes
Difficulty Walking	No	Yes

10. **Hematologic/Lymphatic**

Bruise Easily	No	Yes
Bleeding problems	No	Yes
Swollen glands	No	Yes

11. **Neurologic**

Dizziness	No	Yes
Head Injury	No	Yes
Paralysis	No	Yes
Numbness in feet	No	Yes
Memory Loss	No	Yes

12. **Psychiatric**

Satisfied with life	No	Yes
Insomnia	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Suicidal thoughts	No	Yes

Signature: _____

Date: _____