

Patient name: _____ Date: _____

Review of Systems: Please indicate any personal history below:

-Constitutional Symptoms

Recent weight loss No Yes
 Fever No Yes
 Night Sweats No Yes

-Eyes

Glasses No Yes
 Contacts No Yes
 Double Vision No Yes
 Glaucoma No Yes
 Cataracts No Yes

-Ears/Nose/Mouth/Throat

Hearing Loss No Yes
 Earaches No Yes
 Chronic sinus prob. No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Sore throat No Yes

-Cardiovascular

Chest pain/angina No Yes
 Palpitations No Yes
 Shortness of breath
 with walking No Yes
 with lying flat No Yes
 Swelling of feet, ankles,
 hands No Yes
 Pacemaker No Yes

-Respiratory

Chronic or frequent cough No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

-Gastrointestinal

Loss of appetite No Yes
 Nausea No Yes
 Vomiting No Yes
 Change in bowel habits No Yes
 Frequent diarrhea -
 3 or more/day No Yes
 Constipation (less than
 1/day) No Yes
 Painful bowel
 movements No Yes
 Blood on toilet paper No Yes
 Dark tarry stools No Yes
 Clay colored stools No Yes
 Orange urine No Yes
 Heartburn No Yes
 Abdominal pain No Yes

- Genitourinary

Frequent urination No Yes
 Burning or painful
 urination No Yes
 Blood in urine No Yes
 Incontinence or
 dribbling No Yes
 Kidney Stones No Yes

MALE

Change in force of
 stream when urinating No Yes
 Testicular swelling No Yes
 Testicular Pain No Yes
 Difficult with erection No Yes

FEMALE

Pain with periods No Yes
 Irregular periods No Yes
 Vaginal discharge No Yes
 Unusual vaginal
 bleeding No Yes

-Musculoskeletal

Joint pain No Yes
 Joint stiffness or
 swelling No Yes
 Weakness of muscles No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty walking No Yes

-Integumentary

Rash No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast discharge No Yes
 Sores that won't heal No Yes
 Change in wart or mole No Yes

-Neurological

Headaches No Yes
 Convulsions/seizure No Yes
 Numbness or tingling
 sensations No Yes
 Tremors No Yes
 Paralysis No Yes

-Psychiatric

Memory loss No Yes
 Depression No Yes
 Insomnia No Yes

- Endocrine

Hair loss No Yes
 Hoarseness No Yes
 Goiter No Yes
 Heat intolerance No Yes
 Cold Intolerance No Yes
 Excessive thirst No Yes

-Hematologic/Lymphatic

Bleeding tendency No Yes
 Bruising tendency No Yes
 Anemia No Yes
 Blood clots No Yes
 Past transfusion No Yes
 Enlarged glands No Yes
 Bleeding after dental
 work No Yes

-Allergic/Immunologic

Immunizations current No Yes
 Penicillin allergy No Yes
 Allergy to local
 anesthetics No Yes
 Seafood allergy No Yes
 Latex allergy No Yes
 Iodine allergy No Yes
 Aspirin allergy No Yes

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 Doctor signature

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