**REVIEW OF SYSTEMS**

This guide provides examples of questions for use when investigating system pathology while taking a case. Symptoms of a Presenting Complaint can be identified as related to specific systems of the body and leads the practitioner to further investigate those systems indicated. ROS questioning is applied to better understand the likely causes of a presenting symptom and screen the client for any other underlying important clinical conditions.

Information about a presenting complaint is extrapolated by utilising Cardinal 8 Attributes (LOPQRSTU) mnemonics questioning style and by investigating History of Complaint. When completing a Review of Systems, use Cardinal 8 Attributes to further investigate a system only when the symptom is acute in presentation or important to the further understanding of the case.

**Contents**

[Review of Systems](#page1) [1](#page1)

[Contents](#page1) [1](#page1)

[Review of Systems (ROS) Questions](#page2) [2](#page2)

[GIT](#page2) [2](#page2)

[Nervous System](#page3) [3](#page3)

[Endocrine System](#page5) [5](#page5)

[Immune System](#page6) [6](#page6)

[Respiratory System](#page6) [6](#page6)

[Cardiovascular System](#page7) [7](#page7)

[Urogenital System](#page7) [7](#page7)

[Reproductive System](#page8) [8](#page8)

[Musculoskeletal System](#page9) [9](#page9)

[Integumentary System](#page9) [9](#page9)

[Liver](#page9) [9](#page9)

**Review of Systems (ROS) Questions**

I am now going to ask some questions about other areas of your body related to your presenting complaint, are you comfortable with this (or is this ok with you)? If at any time you do not understand any of my questions, please ask me to clarify.

**GIT**

I’m now going to ask you questions about your digestive system.

1. Do you have any past digestive disorders? o How is your appetite?

o Do you have any food intolerances or food allergies?

o Do you have any: (…if yes, then 8 cardinals LOPQRSTU when symptom is acute or important to further understanding of the case)

* + Burping?
    - Does it taste or smell bad?
  + Heartburn?
* Nausea or vomiting?
* Bloating?

How soon after eating (<1hr stomach, gallbladder, >1hr intestine, pancreas)

* Abdominal pain?
  + L - Where is the pain?
  + O – When does this occur
  + P – Is there anything that makes it better or worse?
  + Q - Can you describe it? (Sharp, gnawing, dull)
  + R – Does the pain radiate? Where to?
  + S – How bad is it on a scale of 1-10?
  + T – Does this pain occur at any particular time? What time of day does this occur?

o How are your bowel movements?

* How often do you go to the toilet for a bowel motion a day?
* Do you feel complete evacuation or empty when done?
* Are they well formed, watery or hard? (Bristle stool chart)
* What color are they?
* Do you ever use laxatives?
* Do you suffer from constipation or diarrhea (LOPQRSTU)
  + O – Have you noticed anything that bring this on?
  + P – Is there anything that makes it better or worse?
  + Q – Can you describe them?

1. Do you ever notice any undigested food in them?

**Nervous System**

1. How do you feel in yourself?
2. How do you feel generally with everyday life? o Are you satisfied with life in general?

o Are you stressed? (LOPQRSTU)

* + How does that feel for you? Can you describe it? How do you experience it?
  + How often?
  + Does it impact on your life? Relationships?
  + How do you manage/relieve stress?
  + Do you exercise regularly?

1. How is your sleep quality? (LOPQRSTU)
   * How many hours do you get each night/day?
   * What time do you go to sleep?
   * How long does it take to get to sleep?
   * Do you wake during the night? What time? How long does it take to get back to sleep?
   * What time do you wake up in the morning?
   * Are you tired on waking? (LOPQRSTU) On a scale of 1-10, rate your energy levels upon waking?
2. Do you have any diagnosed mental health disorders?
   * When did that start?
   * When were you diagnosed?
     + Are you on prescription medication for this?
       - Do you take it regularly?
   * Is there anything that makes that better or worse?
   * How does that affect your daily life?
   * Does that affect any other aspects of your life?
   * How bad is it for you? Are you coping?
3. Do you have a good support network? o How are your relationships?

o What self-care do you do to manage situations? o Do you suffer from anxiety?

* + How often?
  + What starts it?
  + What makes it better/worse?
  + What do you feel when you’re having your attacks?
  + What do you do to calm yourself down?
  + How long do these attacks last?

* How long have you suffered from these attacks?
* What were you doing at the time?
* How are you in large social situations?

1. Do you suffer from depression?
   * On a scale of 1-10 how satisfied are you with your life?
   * How often do you feel down?
   * What is going on at the time?
   * What helps to bring you back up?
   * Are you currently on medication to manage it?
   * Do you have a good support network?
   * How are your relationships?
   * What self-care do you do to manage your situations?
   * Do you believe that your behavior changes? When? Why? Is it sudden/unexpected?

o Do you suffer memory problems or confusion?

o Do you suffer from constipation or diarrhoea? Further questions on GIT may be indicated if yes, but could be linked to the NS.

o Do you drink Alcohol?

* + How drinks per day?
  + What times of day?

1. Do you drink coffee?
   * How many cups per day?
   * What times of day?
2. Do you drink energy drinks?

* How many cups per day? What times of day?

1. Have you taken recreational drugs in the past? (Or currently) o Do you suffer from headaches or migraines?
   * Could you describe how they feel?
   * Could you show me where you feel them?
   * How long do they last?
   * How often do they occur?
   * Can you link it to a particular situation which may occur before?
   * o Do you suffer from dizziness?
   * How long does it last?
   * How often does it occur?
   * What are you doing at the time?
   * What makes it better/worse?
2. Have you ever suffered a seizure?
   * How long did it last?
   * Has it happened more than once?
   * Has the condition been diagnosed?
   * What were you doing at the time?
3. Do you suffer any tingling or numbness in your hands/arms/legs/feet? o Do you suffer unexplained weakness or loss of function?

o Do you suffer balance problems?

o Do you suffer any abrupt loss or change in level of consciousness?

o Has there been any change in touch sensations that you have noticed? (textures/temperatures)

1. Have you suffered any trauma to your back or neck? o Do you get back/neck pain?
   * Where is the pain located?
   * Does it radiate anywhere?
   * What makes it better/worse?

**Endocrine System**

**Thyroid**

1. Any unexplained weight loss or gain? (LOPQRSTU) o Are you having trouble sleeping? (LOPQRSTU)

o Do you suffer fatigue? What are your energy levels like? 1-10 scaling More specific:

1. Have you had a history of goitre?
2. Do you experience sensitivity to cold or heat? o Do you have dry skin?

o Have you noticed any unexpected hair loss or thinning? (LOPQRSTU)

o Have you felt down or experienced brain fog lately?

o Do you experience irritability or anxiety?

o Have you noticed increased perspiration? o Do you experience heart palpitations?

o So you suffer constipation?

o Do you suffer hoarseness?

**Adrenal**

1. Do you have continuously low energy? Rate energy 1-10 scale
2. Do you have trouble getting up in the morning (you get sufficient hours of sleep, but wake feeling tired)?
3. Are you easily rundown or feeling overwhelmed?
4. Do you feel like you bounce back from stress or a simple illness well?

o Do you crave salty or sweet snacks? Or liquorice?

o Do you feel more awake, alert and energetic in the evening than you do all day? o Have you had any kind of chronic disease, repeated infections or life crisis?

o Do you have a busy, full-on lifestyle? As in you never really stop?

o Do you suffer from excessive sweating or night sweats?

o Do you have difficulty concentrating?

o Have you experienced any weight loss or gain?

o Are you waking threw the night or having difficulty falling asleep?

o Do you experience sensitivity to cold or heat?

o Do you have a tendency of daydreaming? Or brain fog?

o Do you stress or get anxious easily, do you cope well with these?

o How is your appetite?

o Do you get dark circles under your eyes?

o Do you wake up during the night to go to the toilet?

o What is your daily water intake like? Do you feel this is enough?

o Do you experience dreams or nightmares?

o Do you currently smoke? Or have you in the past?

|  |  |
| --- | --- |
|  |  |

1. Do you ever feel down/ depressed, low mood?

o How is your libido? On a scale of 1-10?

o Do you ever experience dry or oily skin?

o Do you experience heart palpitation?

o Do you notice that you have an increased perspiration? If so, how long has this been happing? o Do you suffer blood sugar imbalances?

o Eye pupil test (darken room, shine pen light into eye and watch iris, if can’t hold contraction adrenal fatigue)

**Pancreas**

1. Do you urinate often?
2. Have you an increase in thirst?
3. Do you feel very hungry even though you are eating? o Do you suffer extreme fatigue?

o Do you have blurry vision?

o Do you have weight loss even though you are eating more? (Type 1)

o Do you have tingling, pain or numbness in your hands or feet? (Type 2

o Do you have cuts or bruises that are slow to heal?

**Immune System**

1. How many times per year do you get a cold/flu or other infections?

o What is your recovery time?

o How badly do they affect you?

o Do you have a history of recurrent infections? If so please describe.

o Do you have any allergies or intolerances?

o How do they affect you? o How often, recurrent?

o Have you had any testing? When, What and by Whom? o How well do you heal from wounds?

o Do you have any skin infections? Eczema, acne?

o Do you get tonsillitis or swollen lymph glands?

o Have you any history of glandular fever, chicken pox or other childhood diseases?

o Do you suffer from any fevers, chills or sweats?

o Do you suffer from any growths or lumps?

o Where you vaccinated as a child?

o Do you suffer from UTIs or Thrush?

o Are you currently taking antibiotics or have you ever taken them? o When, why, for how long?

o Did you take a probiotic with that?

o Any reoccurring GIT disturbances? IBS, flatulence, bloating?

o Any chronic muscular skeletal symptoms? Aching joints?

**Respiratory System**

1. How long have you had a cough? (Acute – less than 3 weeks; subacute – 3 to 8 weeks; chronic –

more than 8 weeks)

1. Do you cough up sputum? o What colour is the sputum?

o Does it have an odor?

How much are you coughing up?

1. Is the cough getting worse or better?
2. What time of the day do you cough more? o What does the cough sound like

o Does eat effect your cough?

o Does your cough get worse certain times of the year? o Does exercise effect you cough?

o

o Do you have nasal congestion or a sore throat? o Do you or have you had a fever?

o Do you have a headache? o

o Are you short of breath?

o Do you have a history of heart failure? o Do you have a history of asthma?

o Do your or family have allergies or asthma? o Do you have a chronic health problem?

o Do you or a family member smoke? o What do you do for work?

**Cardiovascular System**

1. Do you have known high or low Blood Pressure?
2. Do you experience chest pain or pressure? Does this pain radiate? o Do you have shortness of breath with rest or with exertion?

o Do you suffer lower extremity oedema? Do your ankles swell?

o Do you suffer palpitations, rapid or irregular heartbeat?

o Do you suffer sudden loss of consciousness (syncope)?

o Do you suffer sudden shortness of breath that awakens you from sleep (Paroxysmal Nocturnal Dyspnoea)?

o Do you suffer high cholesterol?

o Do you have cold hands and/or feet?

o Do you suffer calf/leg cramps/pain with walking or going upstairs? o Do you suffer dizziness?

o Is there any irregular bleeding or bruising?

**Urogenital System**

Do you suffer:

1. pain or burning with urination? o frequent or urgent urination?

o incontinence – cannot control bladder? o difficulty starting or stopping urination? o urination at night?

o urinary tract infections? o kidney infections?

o flank pain?

o blood in urine?

1. kidney stones?
2. urethral discharge?
3. incomplete emptying of bladder? o difficulty starting/stopping stream? o genital sores?

o testicular problems?

o prostate problems?

o hernias?

o pain with intercourse?

**Reproductive System**

***Male***

1. General questions see genital/urinary.
2. Has your partner had difficulty conceiving?
3. Do you have any diagnosed Sexually Transmitted Diseases?
4. How is your libido and sexual performance? Do you suffer from impotence? o Do you have any rash, growths or sores that don’t heal on your genitals? o Do you have testicular lumps?

o Do you or have you had multiple sexual partners?

1. Are you on the pill?
   * What brand?
   * Why are you on the pill?
   * Do you take the sugar pills?
2. Do you use any other sort of contraception

o Do you have a menstrual cycle?

* + Is it regular?
  + What is the normal length of your cycle? What is the period of time from the start of one bleed to the start of the next bleed?
  + What is the length of the bleed?
    - What is the pattern of the bleed?
      * Is it heavy? How many pads would you use a day?
    - Are there any clots? How big are they, five cent piece size or twenty cent piece size?
    - What colour is the blood? Bright red? Dark red? Brown? Light red?
    - Is there any pain (LOPQRSTU)?
      * How long does the pain last?
      * Do you use any medication for the pain?
* Do you have any break through bleeding?

1. Do you suffer premenstrual tension, headaches, cravings, bloating, sore breasts, fluid retention and/or pain?
2. Are you or have you gone through menopause? Hot sweats? o Are you on HRT?

o How is your libido?

o Do you have any irregular discharge?

o Do you have or have had any infections?

1. Have you had difficulty conceiving?
2. When was your last PAP smear and what was the result?

o Do you suffer from any Sexually Transmitted Disorder?

o Any Surgery?

o How many pregnancies?

o How many miscarriages or terminations?

o Do you have any breast mass, pain or discharge?

o Do you or have you had multiple partners

**Musculoskeletal System**

1. Do you or have you had any injury? (LOPQRSTU)

o Do you suffer from any known disease?

o Have you any pain? (LOPQRSTU) o Do you suffer muscle cramps?

o Do you suffer joint pain or swelling? What joints?

**Integumentary System**

1. Are you suffering hair loss or thinning?
2. Do you have or have you had any skin condition?

o How is it treated?

o Do you suffer from any skin eruptions, rashes, growths?

o Do you suffer from wounds that don’t heal?

o Do you have lesions that have changed in size, shape or colour?

o Do you have itching?

o Do you have any skin discolorations?

1. How much do you drink? How many would you consume in a day? Week? What type of alcohol do you enjoy drinking?
2. Do you smoke? How many would you have in a day? A week? o Any recent travel?

o Have you had any blood transfusions?

o Have you ever had hemodialysis?

o Do you work in healthcare? Any needle sticks?

o Any tattoos? Have you any body piercings?

o Have you ever had any recreational drugs?

o Are you on any supplements? How often? Are they self-prescribed?

o Any recent mushroom ingestion?

o Any unprotected sex?

o Are you a Vietnam veteran?

o Do you own a dog or cat? {worms/hydatid disease} o How was your infancy, childhood, adulthood?

o How is your over-the-counter medication intake? Do you take aspirin or Panadol regularly? What do you take this for? Are these self-prescribed? How long have you been taking these?

o Have you ever taken antibiotics before? o What were the antibiotics for?

o Are you currently on any medication?

o Do you suffer with headaches or migraine headaches? Can you show me where you experience these headaches?

o Can you rate these headaches: 0 being lowest, 10 being extremely painful

o What can help alleviate these headaches?

o Do you suffer with allergies/intolerances? What types: food, toxins etc.? What type of reaction do you experience?

o Have you ever been diagnosed for Epstein Barr Virus?

o What other childhood diseases have you had?

o Have any of these illnesses had recurred?

o Do you have a fever now?

o What type of hobbies do you do?

o What type of occupation do you have?

o Do you come into contact with chemicals often or animals?

o in your own words can you describe how that chemical makes you feel?

o Are you sensitive to smells? Do certain smells affect you, like make you feel nauseous or give you a headache?

o When do you actually feel nauseous before or after a meal? o Do you get a bitter taste after eating or drinking?

o How are your energy levels?

o Do you suffer with exhaustion or fatigue?

o When’s the best time of day for you?

o When’s the worst time of day?

o Do you do anything to alleviate your fatigue? Does it help?

o Do you feel discomfort after you have eaten a fatty meal?

o Can you feel uncomfortable in the abdomen after you have eaten?

o Can some foods make your stomach feel irritated?

o Can you describe in your own words how this irritation feels? o Can you actually show me where you feel this discomfort?

1. Do you suffer Nausea? Rate the severity of your nausea on a scale of 0-10, 0 being no nausea, 10 being severe?
2. How often in a day do you feel nauseous?
3. Is there anything which helps to alleviate nausea?

o How long does this last for? [short period/prolonged] o Anything which makes the nausea worse?

o Can you feel light headed with your nausea?

o Can this happen when you move your head a certain way?

o Where were you and what were you doing when you felt giddy? o Do you suffer motion sickness?

o Can this actually lead to vomiting?

o Do you suffer with indigestion after eating, especially with fatty or greasy foods?

o Do you experience burping? When does this occur? Is it acidic?

o Do you experience hiccups?

o What makes this indigestion worse?

o What alleviates this indigestion?

o How much water do you drink?

o What other fluids do you consume throughout the day?

o What colour is your urine? Have you experienced dark urine? When? For how long?

o What are the colour of your stools? Are they pale or light in colour?

o What are your bowel movements like? [soft/hard] Do you suffer with diarrhoea or constipation?

o When you defecate is it smelly?

o Do your stools float?

o Do you have itching anywhere on your body? Especially the legs? o Is this itchiness experienced anywhere else?

o Have you had any bleeding from your gastrointestinal tract? What colour is the blood? How long ago?

o Have you any swelling or bloating around your abdomen?

o What time of day do you notice or experience the bloating?

o Were you eating anything or doing anything in particular when you noticed the swelling? o Do you experience swelling anywhere else?

o Do you suffer pain or tenderness under the rib cage on the right side?

o Can you describe the pain for me?

o How would you rate the pain: 0 being the lowest, 10 being severe?

o Do you experience any between your shoulder blades?

o Does it hurt to breathe?

o Does it hurt to inhale or exhale?

o Have you been experiencing shortness of breath?

o Can you describe in your own words the discomfort you are experiencing? o Does this pain radiate too anywhere else?

o Do you experience pain in your left arm?

o Do you noticed if your ankles are swollen? What time of day?

o Have you experienced any tingling or numbness?

o Where have you experienced this numbness? {Fingers/toes}

o Have you had any unexplained weight loss?

o Have you had any weight gain recently? o Do you have a loss of libido?