**REVIEW OF SYSTEMS (ROS)**

**(Please complete the form by checking the boxes that you have current concerns about.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| **Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| **Constitutional** | □ | Fever | **Urology** | □ | Frequent urination |
|  | □ | Significant weight change | □ | Urinary incontinence |
|  |  |
|  | □ | Significant appetite change |  | □ | Pain with urination |
|  |  |  |  | □ | Blood in urine |
|  |  |  |  | □ | Urinary urgency |
|  |  |  |  |  |  |
| **Eye** | □ | Vision problems | **Musculoskeletal** | □ | Joint pain |
|  | □ | Eye irritation |  | □ | Joint swelling |
|  | □ | Eye pain |  | □ | Joint stiffness |
|  |  |  |  | □ | Low back pain |
|  |  |  |  | □ | Neck pain |
|  |  |  |  |  |  |  |
| **ENT** | □ | Nosebleeds | **Neurology** | □ | Chronic headache |
|  |  |
|  | □ | Cold symptoms |  | □ | Passing out |
|  | □ | Voice changes |  | □ | Confusion |
|  | □ | Hearing problems |  | □ | Seizures |
|  |  |  |  | □ | Dizziness |
|  |  |  |  |  |  |  |
| **Respiratory** | □ | Chronic cough | **Dermatology** | □ | Rash |  |
|  |  |  |
|  | □ | Shortness of breath |  | □ Worrisome moles |
|  | □ | Wheezing |  | □ Skin lesions |
|  | □ Loud snoring /stop breathing |  |  |  |  |
|  |  | when sleeping |  |  |  |  |
|  |  |  |  |  |  |  |
| **Cardiovascular** | □ | Chest pain | **Mental Health** | □ | Sadness |
|  |  |
|  | □ | Leg swelling |  | □ | Feeling anxious |
|  | □ | Palpitations (racing heart or |  | □ | Chemical dependency |
|  |  | skipped beats) |  | □ | Do you feel unsafe? |
|  |  |  |  |  |  |
| **Gastroenterology** | □ | Difficulty swallowing | **Endocrinology** | □ | Feeling too cold or too hot |
|  | □ | Heartburn |  | □ | Frequently thirsty |
|  | □ | Abdominal pain |  |  |  |  |
|  | □ | Nausea |  |  |  |  |
|  | □ | Diarrhea |  |  |  |  |
|  | □ | Constipation |  |  |  |  |
|  | □ | Blood in stools |  |  |  |  |
| **Male Reproductive** | □ | Concern for Sexually | **Hematology – Oncology** | □ | Swollen glands |
|  |  | Transmitted Disease (STD) |  | □ | Easy bruising |
|  | □ | Testicular lump/pain |  |  |  |  |
|  | □ Penile discharge or lump |  |  |  |  |
|  | □ Problems with sexual function |  |  |  |  |
|  |  |  |  |  |  |  |
| **Female Reproductive** | □ | Concern for Sexually | **Additional Information** | I have an Advance Directive |
|  |  |
|  |  | Transmitted Disease (STD) |  | □ | Yes | □ No |
|  | □ Breast lumps, breast concerns |  | I am an Organ Donor |
|  | □ | Abnormal vaginal discharge |  |
|  |  | □ | Yes | □ No |
|  | □ | Painful intercourse |  |
|  |  | I am interested in discussing: |
|  | □ | Menstrual cycle concerns |  |
|  |  | □ | Advance Directive |
|  |  |  |  |
|  |  |  |  | □ | Organ donation |
|  |  |  |  |  |  |  |

