**REVIEW OF SYSTEMS QUESTIONS**

**Instructions: Please answer each question by placing a mark in the “Present” column if you currently have the problem. If you had the problem in the past, please write in the approximate date that you experienced it in the “Past (Date)” column. Where appropriate, please write in any additional information requested in the indicated areas.**

|  |  |  |
| --- | --- | --- |
| **General** | **Past (Date)** | **Present** |
| * Do you ever feel unusually weak or fatigued? |  |  |
| * Has there been a change in your energy level?   + Rate current energy level (1-10) \_\_\_\_\_\_   + If there has been a change, when was it? |  |  |
| * Has there been an unexpected change in your weight?   + How much do you weigh now \_\_\_\_\_\_\_, one year ago \_\_\_\_\_\_\_, heaviest \_\_\_\_\_\_\_, lightest \_\_\_\_\_\_\_\_, preferred \_\_\_\_\_\_\_\_ |  |  |
| * Has there been an unexpected change in your appetite or food cravings?   + If there has been a change, when and what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   + How would you describe your current appetite? |  |  |
| * Has there been a change in your sleep quality or habits?   + At what time do you generally fall asleep?   + At what time do you wake up?   + Do you wake feeling rested?   + Do you wake during the night for any reason (urination, insomnia, pain, stress, etc.)?   + Have you ever perspired in your sleep or woke up soaked in sweat? |  |  |
| * Have you had trouble regularly being too hot or cold? * If so, which one? |  |  |
| **Skin** |  |  |
| * Have you experienced skin or hair changes? |  |  |
| * + Moisture (dry or hydrated)? |  |  |
| * + Temperature (warm or cold)? |  |  |
| * + Texture (rough, patchy, scaly, etc.)? |  |  |
| * Do you have any itchiness or rashes? |  |  |
| * Have you gained or lost hair unexpectedly? |  |  |
| **HEENT (Head, Eyes, Ears, Nose, and Throat)** |  |  |
| Have you ever had any problems with your head? |  |  |
| * Do you experience any headaches? * If so, describe them: |  |  |
| * Have you suffered from any head trauma or injury? * If so, describe: |  |  |
| **HEENT (Continued)** | **Past (Date)** | **Present** |
| * Have you been recently exposed to any toxic substances? If so, describe them and the circumstances: |  |  |
| * Have you experienced any loss or alterations of consciousness, dizziness, vertigo, light headedness, “black outs”? |  |  |
| Have you had any problems with your eyes? |  |  |
| * How is your vision? Have you experienced a sudden change in vision or loss of vision? |  |  |
| * Have you ever used any corrective eyewear? * If so, glasses, contacts or vision repair? |  |  |
| * Are you able to see well at night? |  |  |
| * Do you ever have any pain in your eyes? |  |  |
| * Do you ever experience any dryness or tearing? |  |  |
| Have you had any problems with your ears? |  |  |
| * How would you describe your hearing? * Has there been any change? |  |  |
| * Do you ever have a ringing in your ear? * If so, what pitch high or low? |  |  |
| * Do you have any difficulty distinguishing one voice in a conversation in a crowded room? |  |  |
| * Do you ever have any pain in your ears? |  |  |
| * Do you ever have any dryness in your ears? |  |  |
| Have you had any problems with your nose? |  |  |
| * Have you ever had any sinus infections? |  |  |
| * Do you ever experience any discharge from your nose (mucus, blood, crusts) |  |  |
| * + If so, how much, how often and for how long? |  |  |
| * Do you experience frequent sneezing? If so in what environment? |  |  |
| Have you ever had any problems with your throat? |  |  |
| * Have you had sore throats in the past? * If so, did you ever test positive for Strep? |  |  |
| * Do you still have your tonsils? If removed, when? |  |  |
| * Have you ever had any swelling around your throat? |  |  |
| * Do you ever experience neck pain? |  |  |
| * Have you had hoarseness or difficulty speaking? |  |  |
| Have you ever had any problems with your mouth? |  |  |
| * Do you ever experience any pain in your mouth or teeth? * If so, is it made worse by chewing or certain temperatures? |  |  |
| * Do you ever experience any bleeding or sores in your mouth? |  |  |
| * Have you had any cavities? |  |  |
| * Have you ever had a root canal or any of your teeth removed due to disease? |  |  |
| * Do you use any dental appliances (denture, retainer, braces, bridge)? |  |  |
| **HEENT (Continued)** | **Past (Date)** | **Present** |
| * Have you had problems with dry mouth or drooling? |  |  |
| * Have you had any problems with chewing or speaking? |  |  |
| * Do you grind your teeth and/or have TMJ? |  |  |
| **Respiratory System** |  |  |
| * Do you ever have any pain or difficulty breathing? |  |  |
| * Are you ever short of breath? * Can you walk up a flight of stairs without being winded? * If you rest, are you able to continue? |  |  |
| * Do you experience any wheezing? * Have you ever used an inhaler? |  |  |
| * Do you have a cough? * If so, what brings on the cough?   + Does anything come up?   + If so, what color, how much, when is it worse, when is it better?   + Do you cough up any blood? |  |  |
| * How many pillows do you sleep on at night? |  |  |
| * Do you ever wake up gasping for air? |  |  |
| * Have you ever been told that you snore? |  |  |
| * Do you have any history of respiratory infections? |  |  |
| **Cardiovascular** |  |  |
| * Have you ever had any problem with your heart? |  |  |
| Do you ever experience any chest pain?  If so, please describe it (what is the sensation, does it radiate, what brings it on, what makes it better): |  |  |
| * Do you ever experience any heart palpitations (or fluttering or anxious sensation in your chest)? If so, when do you notice them and what makes them better or worse? |  |  |
| * Have you ever been told you have a murmur or an irregular heartbeat? |  |  |
| * Do you have history of high or low blood pressure? |  |  |
| * Do you have any varicose veins or hemorrhoids? |  |  |
| * Do you bruise easily or do bruises last longer than 2 weeks? |  |  |
| * Have you ever had a blood clot? |  |  |
| * Do you ever experience any muscle cramping at night? |  |  |
| * Do you ever experience any pain in your legs while walking? |  |  |
| * Do you ever notice if your fingers change color, maybe pale or blue? |  |  |
| * Have you ever had any headache with sudden dizziness, loss of consciousness, or loss of ability to do any normal activities or movements? * If so, please describe: |  |  |
|  |  |  |
| **Gastrointestinal** | **Past (Date)** | **Present** |
| * Have you ever had any problems with your digestion? |  |  |
| * Do you have any abdominal pain? * If so, when and where? |  |  |
| * Have you ever experienced frequent nausea? |  |  |
| * + If so, when and for how long, and what makes it better or worse? |  |  |
| * Have you had a change in appetite? |  |  |
| * Have you vomited recently? * If so, how often? |  |  |
| * Do you have any difficulty or pain on swallowing? |  |  |
| * Are you able to eat a full-size meal? |  |  |
| * Do you ever experience indigestion? If so with what is the sensation and with what type of meal? |  |  |
| * Do you ever experience any pain or burning after eating? * Do you experience any pain or burning if you lay down after eating? |  |  |
| * Do you have any known food allergies? * If so, what are you allergic to and have you ever been tested or treated for them? |  |  |
| * Do you experience any gas or bloating after meals?   + How long after meals?   + Where do you feel it?   + Does eructation (belching) or flatus (farting) make it better? |  |  |
| * Have you had any problems with your bowel movements?   + How many bowel movements do you have per day?   + Per week?   + Is there any pain when passing the bowel movement?   + What is the bowel movement like, well formed, runny, hard or soft?   + What color is it (brown, white, clay colored, dark brown-blackish, exotic (think food additives))?   + Is there any mucus, pus, blood (bright red streaks, bright red or dark black (like molasses or coffee grounds)?   + Have you had a change in bowel habits?   + If so, when? |  | |
| * Have you experienced jaundice or been told you have a problem with your liver? |  |  |
| **Urinary Tract** |  |  |
| * Have you had any problems with your kidneys, bladder, or urination? |  |  |
| * How often/frequently do you urinate during the day? At night? |  |  |
| * What color is your urine, usually? (watery/clear, light yellow, straw, yellow, neon yellow (vitamin), golden, dark yellow, greenish, orange, red, brown) |  |  |
| * Do you experience urgency? (If so, how long can you hold it?) |  |  |
| * Do you ever have any accidental urination (just a few drops), like from laughing, sneezing, coughing or with exertion? |  |  |
| * Do you have any problems starting urination? |  |  |
| * Do you experience any intermittent stream or stopping during urination? |  |  |
| **Urinary Tract (Continued)** | **Past (Date)** | **Present** |
| * Do you experience any pain on urination?   + If so, where do you feel the pain and what is it like (burning, stinging, stabbing, radiating)?   + Is the pain relieved by voiding (urination)? |  |  |
| * Have you ever noticed any blood in your urine? Mucus? Sediment or things you see sift to the bottom? |  |  |
| * Have you had any urinary tract infections in the past? |  |  |
| * Have you ever known to have had an STD (sexually transmitted disease)? |  |  |
| **Reproductive System** |  |  |
| * Have you had any problems with your reproductive system not covered elsewhere in this questionnaire? If so, please describe: |  |  |
| **Musculoskeletal** |  |  |
| * Are you able to exercise? If no, are there any certain activities that you have limited participation in? |  |  |
| * Do you have any recent or past muscle, bone, or joint injuries? |  |  |
| * Do you have any heat, swelling, redness, or pain? * Do these places improve with cold application or oral anti-inflammatory use? |  |  |
| * Do you have any joint stiffness? If yes, does it get better with motion, if so, how soon does it get better? |  |  |
| * Do you have any muscle stiffness? If yes, does it get better with motion or stretching? What did you do the day before? |  |  |
| * Have you noticed any weakness in certain areas? |  |  |
| * Have you noticed any shrinking of your muscles? |  |  |
| * How is your back and neck? |  |  |
| * Have you ever been in a car accident or any other accidents that may have affected your back? |  |  |
| **Endocrine** |  |  |
| * Have you been told that you have any thyroid problems? |  |  |
| * Have you noticed any change in the pitch of your voice? |  |  |
| * Do you feel like you urinate too much? |  |  |
| * How often do you feel thirsty? If you drink, are you able to quench your thirst? |  |  |
| * Does your appetite sometimes seem excessive? How long can you comfortably without eating? |  |  |
| **Central Nervous System**  Headache, syncope [fainting, "blackouts"], seizures, vertigo, diplopia, paralysis/paresis, muscle weakness, tremor, ataxia, numbness, tingling, memory disturbances, problems with bowel or bladder control, in coordination |  |  |
| * Have you ever experienced a seizure? If so, do you still experience seizures? |  |  |
| * Do you ever feel like the room is spinning or you are spinning? |  |  |
| * Do you ever get double vision or see two pictures of the same object in your mind? |  |  |
| * Have you ever experienced any paralysis or temporary paralysis? |  |  |
| * Have you noticed change in your muscle strength? |  |  |
| * Do you ever get any shaking when doing something? If yes, does it occur before, during or after exertion? * Does it occur at rest? |  |  |
| * Have you ever lost your balance or coordination for what seems like no reason?   + Loss of sensation/decreased sensation/ increased sensation   + Aberrant sensation – burning, prickling, tickling, itching. |  |  |
| * Have you had an accident or lost control of your bowel or bladder? * If so, what were the circumstances? |  |  |
| **Psychiatric**  Anxiety, nervousness, mood changes, depression, sleep disturbance nightmares, memory loss, hallucinations, racing thoughts, changes in appetite, suicidal ideation |  |  |
| * Have you ever experienced any anxiety? * If yes, in what situation and what makes it better or worse? |  |  |
| * Do you have any fears or phobias? |  |  |
| * Do you experience mood changes? If so, how frequently? Do you ever have trouble controlling your emotions? |  |  |
| * Do you ever feel sad or upset?   + If so, how frequently?   + Have you had any recent losses in your life?   + In the last 6 months has it been more days than not that you have felt sad?   + In the last 2 years has it been more days than not?   + Have you had a recent change in appetite or weight due to grief? |  |  |
| * Do you have a difficult time sleeping because of your thoughts or feelings? |  |  |
| * Have you ever seen or heard things that may not necessarily be there, such as hear voices or have visions? |  |  |
| * Do you ever have periods where you don’t remember what you have just done, or you lose track of what you have done for a period of time? |  |  |
| * Have you ever considered suicide?   + If so, when did you consider it?   + What was happening in your life?   + Did you have a plan?   + Did you have a means (weapon or drug cocktail)?   + Do you know how to contact a helpline or other form of mental health assistance if you find yourself considering suicide in the future? |  |  |