**REVIEW OF SYSTEMS**

|  |  |
| --- | --- |
| **Name:** | **Date:** |
| **Date of Birth:** | **MR #:** |
| **Primary Care Physician:** | **Daytime Phone #:** |
|  |  |

**Health History: Please indicate if you have any of the following.**

|  |  |  |
| --- | --- | --- |
| **Constitutional** | **Y** | **N** |
| Fever |  |  |
| Chills |  |  |
| Headache |  |  |
| Recent weight change CIRCLE ONE: |  |  |
| Less than 20 lbs. |  |  |
| More than 20 lbs. |  |  |
| Other |  |  |
|  |  |  |
| **Eyes/Nose/Throat** | **Y** | **N** |
| Glaucoma |  |  |
| Glasses |  |  |
| Sinus Probems |  |  |
| Other |  |  |
|  |  |  |
| **Cardiovascular** | **Y** | **N** |
| Chest Pain |  |  |
| Varicose Veins |  |  |
| High Blood Pressure |  |  |
| Other |  |  |
|  |  |  |
| **Respiratory** | **Y** | **N** |
| Wheezing/Asthma |  |  |
| COPD |  |  |
| Shortness of Breath |  |  |
| Sleep Apnea |  |  |
|  |  |  |
| Other |  |  |
|  |  |  |
| **Endocrine** | **Y** | **N** |
| Diabetes |  |  |
| Thyroid Disorder |  |  |
| Other |  |  |
|  |  |  |
| **Musculoskeletal** | **Y** | **N** |
| Joint Pain |  |  |
| Neck Pain |  |  |
| Back Pain |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal** | **Y** | **N** |
| Abdominal pain |  |  |
| Constipation |  |  |
| Diarrhea |  |  |
| Nausea/Vomiting |  |  |
|  |  |  |
| Indigestion/Heartburn |  |  |
| Other |  |  |
|  |  |  |
| **Hematology** | **Y** | **N** |
| Bleed |  |  |
| Bruise |  |  |
| Aspirin Last 2 Weeks |  |  |
| Other |  |  |
|  |  |  |
| **Neurologic** | **Y** | **N** |
| Tremors |  |  |
| Dizzy Spells |  |  |
| Numbness/Tingling |  |  |
| Other |  |  |
|  |  |  |
| **Genitourinary** | **Y** | **N** |
| Urinary Frequency |  |  |
| Urinary Retention |  |  |
| Painful Urination |  |  |
| Blood in Urine |  |  |
|  |  |  |
| Other |  |  |
|  |  |  |
| **Psychologic** | **Y** | **N** |
| Anxiety |  |  |
| Depression |  |  |
| Other |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient signature:** | |  | **Date:** | |  | **Time:** |
| **Reviewed by:** |  |  | **Date:** |  |  | **Time:** |

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