**REVIEW OF SYSTEMS**

**Responses and Comments:**

**1. General**

Weight

Weight 1 year ago

Maximum weight

When

Height

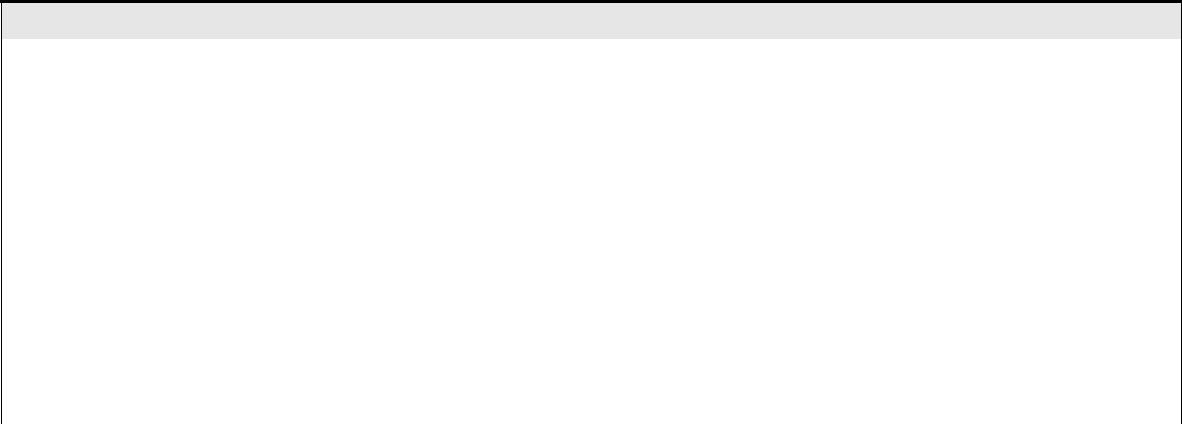
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fatigue/Weakness | Y | P | N |  |
| Fever/Chills | Y | P | N |  |

**2. Skin**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rashes | Y | P | N |  |
| Eczema, hives, acne, boils (circle) | Y | P | N |  |
| Itching | Y | P | N |  |
| Color change | Y | P | N |  |
| Lumps | Y | P | N |  |
| Night sweats | Y | P | N |  |
| Dryness/Moistness (circle) | Y | P | N |  |
| Nail changes | Y | P | N |  |
| Changes in mole | Y | P | N |  |
| Skin cancer | Y | P | N |  |

**3. Head**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headache | Y | P | N |  |
| Head injury (when) | Y | P | N |  |
| Dizziness | Y | P | N |  |
| Hair loss | Y | P | N |  |



**4. Eyes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Impaired vision | Y | P | N |  |
| Glasses/Contacts | Y | P | N |  |
| Eye pain | Y | P | N |  |
| Tearing or dryness (circle) | Y | P | N |  |
| Double vision | Y | P | N |  |
| Glaucoma | Y | P | N |  |
| Cataracts | Y | P | N |  |
| Blurring | Y | P | N |  |
| Itching | Y | P | N |  |
| Redness | Y | P | N |  |
| Discharge | Y | P | N |  |
| Blind spot | Y | P | N |  |

**5. Ears**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Impaired hearing | Y | P | N |  |
| Earache | Y | P | N |  |
| Discharge | Y | P | N |  |
| Infections | Y | P | N |  |

**6. Nose and Sinuses**

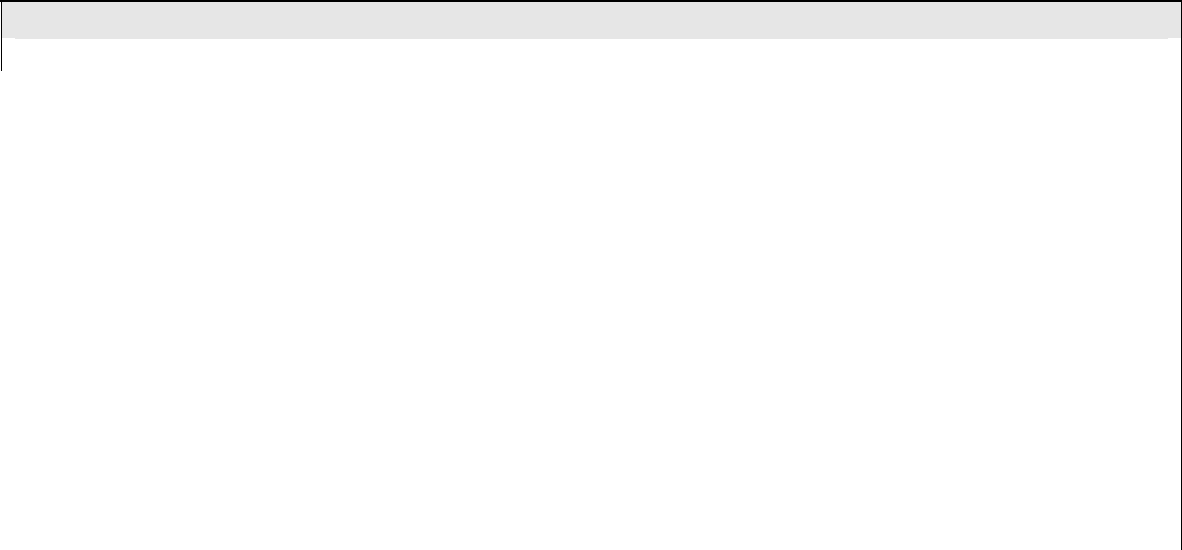
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Frequent colds | Y | P | N |  |
| Nose bleeds | Y | P | N |  |
| Stuffiness/Post nasal drip (circle) | Y | P | N |  |
| Hay fever | Y | P | N |  |
| Sinus problems | Y | P | N |  |

**7. Mouth and Throat**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequent sore throat | (How many times a year) | Y | P | N |  |
| Sore tongue/mouth |  | Y | P | N |  |
| Gum problems |  | Y | P | N |  |
| Hoarseness of voice | (Since when) | Y | P | N |  |
| Dental cavities |  | Y | P | N |  |
| Loss of taste |  | Y | P | N |  |

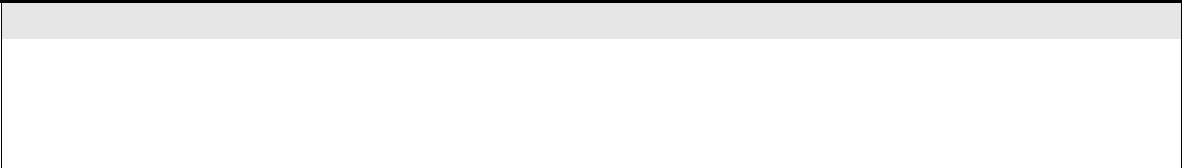
**8. Neck**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pain | Y | P | N |  |
| Lumps/Swollen glands (circle) | Y | P | N |  |
| Goiter | Y | P | N |  |



**9. Respiratory**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cough | Y | P | N |  |
| Sputum (indicate color) | Y | P | N |  |
| Wheezing | Y | P | N |  |
| Asthma | Y | P | N |  |
| Bronchitis | Y | P | N |  |
| Pneumonia | Y | P | N |  |
| Pleurisy | Y | P | N |  |
| Emphysema | Y | P | N |  |
| Difficulty breathing | Y | P | N |  |
| Pain on breathing | Y | P | N |  |
| Shortness of breath | Y | P | N |  |
| Shortness of breath at night | Y | P | N |  |
| Shortness of breath lying down | Y | P | N |  |
| Tuberculosis | Y | P | N |  |
| Tuberculin test | Y | P | N |  |
| Last chest X-ray |  |  |  |  |



**10. Breasts**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you do self-exams? | Y | P | N |  |
| Lumps | Y | P | N |  |
| Pain or tenderness | Y | P | N |  |
| Nipple discharge | Y | P | N |  |

**11. Cardiovascular**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heart disease | Y | P | N |  |
| Angina | Y | P | N |  |
| High blood pressure | Y | P | N |  |
| Murmurs | Y | P | N |  |
| Rheumatic fever | Y | P | N |  |
| Chest pain | Y | P | N |  |
| Swelling in ankles | Y | P | N |  |
| Palpitations, fluttering | Y | P | N |  |
| Cyanosis | Y | P | N |  |
| Past ECG | Y | P | N |  |
| Other heart tests |  |  |  |  |

**12. Gastrointestinal**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Trouble swallowing | Y | P | N |  |
| Heartburn | Y | P | N |  |
| Change in appetite or thirst (circle) | Y | P | N |  |
| Nausea | Y | P | N |  |
| Vomiting | Y | P | N |  |
| Vomiting blood | Y | P | N |  |
| Bowel movements – how often? |  |  |  |  |
| Is this a change? | Y |  | N |  |
| Blood in stool | Y | P | N |  |
| Belching or passing gas | Y | P | N |  |
| Jaundice (yellow skin) | Y | P | N |  |
| Liver disease | Y | P | N |  |
| Gall bladder disease | Y | P | N |  |
| Ulcer | Y | P | N |  |
| Indigestion | Y | P | N |  |
| Diarrhea | Y | P | N |  |
| Rectal bleeding | Y | P | N |  |
| Hemorrhoids | Y | P | N |  |
| Black, tarry stool | Y | P | N |  |
| Abdominal pain | Y | P | N |  |
| Food allergy | Y | P | N |  |
| Hernias | Y | P | N |  |

**13. Urinary**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pain on urination | Y | P | N |  |
| Increased frequency | Y | P | N |  |
| Frequency at night | Y | P | N |  |
| Inability to hold urine | Y | P | N |  |
| Frequent infections | Y | P | N |  |
| Kidney stones | Y | P | N |  |
| Blood in urine | Y | P | N |  |
| Urgency | Y | P | N |  |
| Hesitancy | Y | P | N |  |

**14. Male Reproductive**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Hernias | Y | P | N |  |
| Testicular pain | Y | P | N |  |
| Testicular masses | Y | P | N |  |
| Are you sexually active? | Y | P | N |  |
| Sexual difficulties | Y | P | N |  |
| Venereal diseases | Y | P | N |  |
| Discharge or sores | Y | P | N |  |
| Sexual preference: Heterosexual | Y | P | N |  |
| Bisexual | Y | P | N |  |
| Homosexual | Y | P | N |  |

**15. Female Reproductive**

Age menses began

Average number of days

Length of cycle

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bleeding between periods | Y | P | N |  |
| Are cycles regular | Y | P | N |  |
| Pain during intercourse | Y | P | N |  |
| Painful menses | Y | P | N |  |
| Excessive flow | Y | P | N |  |
| PMS | Y | P | N |  |
| Birth control? | Y | P | N |  |
| What type? |  |  |  |  |
| Number of pregnancies |  |  |  |  |
| Number of live births |  |  |  |  |
| Number of miscarriages |  |  |  |  |
| Number of abortions |  |  |  |  |
| Are you sexually active? | Y | P | N |  |
| Sexual difficulties | Y | P | N |  |
| Venereal disease | Y | P | N |  |
| Sexual preference: Heterosexual | Y | P | N |  |
| Bisexual | Y | P | N |  |
| Homosexual | Y | P | N |  |
| Last menstrual period |  |  |  |  |
| Vaginal discharge | Y | P | N |  |
| Vaginal itching | Y | P | N |  |
| Difficulty conceiving | Y | P | N |  |
| Last PAP smear (date) |  |  |  |  |

**16. Musculoskeletal**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Joint pain or stiffness | Y | P | N |  |
| Arthritis | Y | P | N |  |
| Broken bones | Y | P | N |  |
| Muscle spasms or cramps | Y | P | N |  |
| Weakness | Y | P | N |  |
| Joint swelling | Y | P | N |  |
| Backache | Y | P | N |  |

**17. Peripheral Vascular**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Deep leg pain | Y | P | N |  |
| Cold hands/feet | Y | P | N |  |
| Varicose veins | Y | P | N |  |
| Thrombophlebitis | Y | P | N |  |
| Leg cramps | Y | P | N |  |
| Extremity numbness | Y | P | N |  |
| Extremity coldness | Y | P | N |  |
| Extremity swelling | Y | P | N |  |
| Extremity ulcers | Y | P | N |  |

**18. Neurologic**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fainting | Y | P | N |  |
| Seizures/Convulsions | Y | P | N |  |
| Paralysis | Y | P | N |  |
| Muscle weakness | Y | P | N |  |
| Numbness or tingling | Y | P | N |  |
| Loss of memory | Y | P | N |  |
| Involuntary movement | Y | P | N |  |
| Loss of balance | Y | P | N |  |
| Speech problems | Y | P | N |  |

**19. Endocrine**

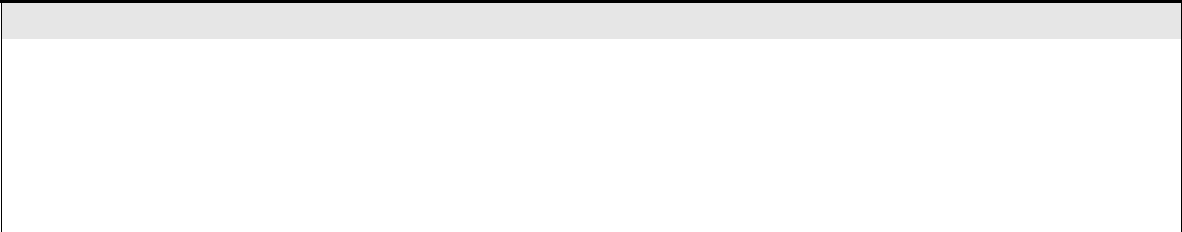
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heat or cold intolerance (circle) | Y | P | N |  |
| Thyroid trouble | Y | P | N |  |
| Excessive thirst | Y | P | N |  |
| Excessive hunger | Y | P | N |  |
| Excessive urination | Y | P | N |  |
| Excessive sweating | Y | P | N |  |
| Diabetes | Y | P | N |  |
| Hypoglycemia | Y | P | N |  |
| Hormone therapy | Y | P | N |  |

**20. Blood/Lymphatic**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anemia | Y | P | N |  |
| Easy bleeding or bruising | Y | P | N |  |
| Past transfusions | Y | P | N |  |
| Lymph node swelling | Y | P | N |  |

**21. Allergic history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug sensitivity | Y | P | N |  |
| Reaction to vaccine | Y | P | N |  |
| Please list any allergies: |  |  |  |  |



**22. Emotional**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depression | Y | P | N |  |
| Mood swings | Y | P | N |  |
| Anxiety/nervousness/tension (circle) | Y | P | N |  |
| Phobias | Y | P | N |  |
| Alcohol/drug abuse | Y | P | N |  |
| Insomnia | Y | P | N |  |