**OBESITY-FOCUSED REVIEW OF SYSTEMS**

**Patient Name**

**Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial**

**Age Sex Male Female Other**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Endocrine** |  |  | **Yes** |  |  | **No** |
| Do you have type 1 diabetes? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have type 2 diabetes? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you been told that you have prediabetes? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have a history of hyperthyroidism (overactive thyroid)? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have history of hypothyroidism (underactive thyroid)? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you or anyone in your family had medullary thyroid cancer? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have dry mouth? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have excessive urination? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have excessive thirst? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Women** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have increased facial hair? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have acne? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have irregular periods? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you been diagnosed with infertility or been told you’re infertile? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Men** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you been diagnosed with low testosterone (low-T)? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have low sex drive? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Obesity-Focused Review of Systems**

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| --- | --- | --- | --- | --- | --- | --- |
| **Endocrine** |  |  | **Yes** |  |  | **No** |
| Have you been diagnosed with erectile dysfunction? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Lung and Breathing Disorders** |  |  | **Yes** |  |  | **No** |
| Do you have a history of asthma? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have a history of COPD (chronic obstructive pulmonary disease)? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you snore? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you been diagnosed with sleep apnea (severe snoring that interferes |  |  |  |  |  |  |
| with your sleep)? |  |  |  |  |  |  |
| Do you wheeze? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you get short of breath when walking? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Cardiac** | **Yes** |  |  | **No** |
| Have you ever been diagnosed with angina? |  |  |  |  |
| Have you ever had a heart attack? |  |  |  |  |
| Have you ever been diagnosed with congestive heart failure (CHF)? |  |  |  |  |
| Have you been diagnosed with heart valve disease? |  |  |  |  |
| Do you get short of breath when laying down? |  |  |  |  |
| Do your feet swell? |  |  |  |  |
| Have you ever been diagnosed with an arrhythmia (irregular heart beat)? |  |  |  |  |
| Have you ever been told you have a heart murmur? |  |  |  |  |
| Do you take medication for high cholesterol? |  |  |  |  |
| Do you take medication for high blood pressure? |  |  |  |  |
| Do you ever have chest pain? |  |  |  |  |

**Besity-Focused Review of System**

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| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Yes** |  |  | **No** |
| Do you have abdominal pain? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you had part of your intestine removed? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you been diagnosed with gastroparesis? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you frequently have diarrhea? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you frequently have nausea? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you vomit frequently? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Psychiatric** |  |  | **Yes** |  |  | **No** |
| Have you ever been diagnosed with depression? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever been diagnosed with anxiety? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever taken medication for depression or anxiety? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever been diagnosed with ADHD (attention deficit hyperactivity |  |  |  |  |  |  |
| disorder)? |  |  |  |  |  |  |
| Have you ever been diagnosed with bipolar disorder? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have trouble sleeping? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have memory loss? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you avoid social interaction because of your weight? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever felt discriminated against because of your weight? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Does being overweight cause you to feel depressed? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you drink more than 2 alcoholic beverages per day? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you take pain medication or opiates on a regular basis? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Obesity-Focused Review of Systems**

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| --- | --- | --- | --- | --- | --- | --- |
| **Oncology** |  |  | **Yes** |  |  | **No** |
| Have you ever been diagnosed with cancer? |  |  |  |  |  |  |
| What type(s): |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever had a colonoscopy? |  |  |  |  |  |  |
| When was the last time?  |  |  |  |  |  |  |
| **Women** |  |  |  |  |  |  |
| Have you ever had a mammogram? |  |  |  |  |  |  |
| When was the last time?  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Obstetrics** |  |  | **Yes** |  |  | **No** |
| Are you pregnant? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Are you nursing? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Are you planning to become pregnant within the next year? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever had trouble getting pregnant or used fertility treatments? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Neurologic** |  |  | **Yes** |  |  | **No** |
| Have you ever had a seizure |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever had a stroke? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have tingling in your fingers or feet? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you have a hand tremor, or does your hand shake when you hold it out? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Have you ever had migraine headaches? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do you take medication to prevent migraines? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Nephrology** |  |  | **Yes** |  |  | **No** |
| Have you been diagnosed with chronic kidney disease (CKD) or diabetic |  |  |  |  |  |  |
| nephropathy? |  |  |  |  |  |  |

**Obesity-Focused Review of Systems**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Joint Diseases** |  |  | **Yes** |  |  | **No** |
| Do you have a history of arthritis? |  |  |  |  |  |  |
| Do you have pain in your knees? |  |  |  |  |  |  |
| Do you have pain in your hips? |  |  |  |  |  |  |
| Do you have chronic back pain? |  |  |  |  |  |  |
| Do you have trouble walking or exercising due to joint pain? |  |  |  |  |  |  |
| Do you take medication for joint or back pain? |  |  |  |  |  |  |
| Have you had a joint replacement (e.g., hip or knee surgery)? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |