

Review Of Systems



Date: _____

Name: _____

Date of Birth: _____

General:	Yes	No	Cardiovascular:	Yes	No
Do you worry a lot about your health?	_____	_____	Do you have pain, tightness or pressure in the front or back of your chest?	_____	_____
Do you usually feel tired and worn out?	_____	_____	If yes, is it when walking fast, working hard, or when excited?	_____	_____
Do you feel depressed a lot of the time?	_____	_____	Have you ever been told that your EKG was abnormal?	_____	_____
Have you recently noticed that heat or warm weather bothers you?	_____	_____	Do you have swelling in your feet or ankles?	_____	_____
Have you recently been drinking more water or fluids?	_____	_____	Does your heart ever beat fast or irregularly?	_____	_____
Has there been any unusual weight gain or loss recently?	_____	_____	Do you get cramps in your calf muscles when you walk?	_____	_____
			Do you ever awaken at night with severe difficulty breathing?	_____	_____
			Do your fingers or toes ever get cold, become numb, or get white or bluish?	_____	_____
				Yes	No
Skin:	Yes	No	Gastrointestinal:		
Have you noticed:			Have you recently had any changes in your eating habits?	_____	_____
any change in your skin color?	_____	_____	Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	_____	_____
any skin rashes or itching?	_____	_____	Do you tend to burp a lot?	_____	_____
unusually dry skin?	_____	_____	Have you recently noted any trouble swallowing?	_____	_____
any bothersome growths on your skin?	_____	_____	Do you have a lot of indigestion or heartburn?	_____	_____
any sores or wounds that do not heal?	_____	_____	Have you ever vomited blood?	_____	_____
any change in color or size of warts?	_____	_____	Are you bothered with constipation?	_____	_____
			Do you have frequent loose stools or diarrhea?	_____	_____
			Do you pass a lot of gas?	_____	_____
			Do you have a poor appetite?	_____	_____
			Do you ever awake at night with the feeling of fullness under your breast bone?	_____	_____
			Have you ever passed blood from your rectum?	_____	_____
			Have you ever had black or tarry stool?	_____	_____
			Have you noticed any recent changes in your bowel movements?	_____	_____
			Do you take laxatives regularly?	_____	_____
			Do you have frequent nausea and/or vomiting?	_____	_____
				Yes	No
Eyes:	Yes	No	Genitourinary:		
Have you had:			Do you have:		
any pain in your eyes?	_____	_____	anything wrong with your genitals (privates)?	_____	_____
glaucoma?	_____	_____	burning or pain when urinating?	_____	_____
blurry vision?	_____	_____	to pass water frequently?	_____	_____
halos around lights?	_____	_____	to pass more water than you used to?	_____	_____
change in vision?	_____	_____	trouble passing water?	_____	_____
			to get up at night to urinate?	_____	_____
			trouble with losing urine when you cough or sneeze?	_____	_____
			a problem dripping urine?	_____	_____
			Have you ever passed blood in your urine?	_____	_____
			Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	_____	_____
			<i>MEN</i> - Do you have prostate gland trouble?	_____	_____
				_____	_____
Respiratory:	Yes	No			
Do you have:					
frequent chest colds?	_____	_____			
a constant or bothersome cough?	_____	_____			
coughing of blood?	_____	_____			
sputum or phlegm between colds?	_____	_____			
difficulty breathing?	_____	_____			
wheezing/whistling in your chest?	_____	_____			

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Musculoskeletal:

Yes No

- Do you have a problem with back pain? _____
- Do you have pain in your legs or feet? _____
- Does back pain interfere with your work or activities? _____
- Do you have joint pain or stiffness? _____
- Do you have trouble walking or using your hip or knee joints? _____

Personal Habits:

Yes No

- Do you regularly smoke: _____
- Cigarettes: _____
- How many per day? _____
- For how many years? _____
- Pipe, Cigars or use Chewing Tobacco: _____
- For how many years? _____
- Are you a former smoker/tobacco user? _____
- If so, how long ago did you quit? _____

Central Nervous System:

Yes No

- Do you have frequent or severe headaches? _____
- Do you often have spells of dizziness, faintness or lightheadedness? _____
- Have you seen double? _____
- Do you sometimes lose track of what happens around you for a short time? _____
- Do you sometimes lose the ability to speak for a few seconds? _____
- Have you recently fainted, blacked out or lost consciousness? _____
- Do you have trouble remembering recent events? _____
- Have you ever had convulsions or fits? _____
- Do you have numbness or tingling in your head, arms or legs? _____
- Do you consider yourself a nervous person? _____
- Do you cry a lot for no reason? _____
- Have you ever had an urge to commit suicide? _____
- Do you ever hear voices or see people when no one is around? _____
- Do you ever have a feeling that someone is trying to harm you? _____

- Do you drink: _____
- Hard Liquor: _____
- 1-3 oz per day _____ over 3 oz per day _____
- Beer: _____
- 1 bottle a day _____ 2 bottles _____ 3 or more _____
- Wine: _____
- 1 glass a day _____ 2 glasses _____ 3 or more _____
- Do you drink coffee? _____
- Do you drink 3 or more cups a day? _____
- Do you have difficulty sleeping? _____
- If yes, how often? _____
- Do you awaken very early in the morning without an apparent cause and find it difficult to go back to sleep? _____
- If yes, how often? _____
- Do you exercise? _____
- # of days a week _____ Minutes a day _____
- If you exercise, how intense is your exercise? _____
- Light _____ Moderate _____ Heavy _____ Very Heavy _____
- Do you wear a seat belt when traveling in a car? _____
- Are you sexually active? _____
- Have you had more than one partner in the past 2 years? _____
- Do you protect against STD's? _____
- Do you use contraception/birth control? _____

Women Only

Yes No

- Did your menstrual cycle start before you were 10? _____
- Did your menstrual cycle start after you were 15? _____
- Are your menstrual cycles irregular? _____
- Are your periods less frequent than every 4 weeks? _____
- Are your periods more frequent than every 4 weeks? _____
- Do you use more than 10 pads or have to use a super size pad or tampon for your periods? _____
- Do you pass clots with your periods? _____
- Do you become bloated or gain weight just before your periods? _____
- Have you passed the menopause or change? _____
- Do you have hot flashes? _____
- Have you had an abortion or miscarriage? _____
- Have you had lumps in your breast? _____
- Have you had any discharge from your nipples? _____
- Have you used an intrauterine device (IUD)? _____
- Have you used other birth control measures? _____