

Patient: _____

Date: _____

REVIEW OF SYSTEMS

Do you now have any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other _____

Integumentary

Skin rash Y N
Boils Y N
Persistent itch Y N
Other _____

Eyes

Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Musculoskeletal

Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Allergic/Immunologic

Hay fever Y N
Drug allergies Y N
Other _____

Ear/Nose/throat

Ear infection Y N
Sore throat Y N
Sinus Problem Y N
Other _____

Neurological

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Genitourinary

Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other _____

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Gastrointestinal

Abdominal pain Y N
Nausea?vomiting Y N
Indigestion?heartburn Y N
Other _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other _____

Cardiovascular

Chest pain Y N
Varicose Veins Y N
High blood pressure Y N
Other _____

Psychologic

Are you unhappy with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _____