

Patient Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS

Current problems: (Check all that apply)

CONSTITUTIONAL

- Fever
- Excessive Fatigue
- Weight Loss
- Night Sweats

EYES

- Wear Glasses
- Infections
- Glaucoma
- Date of Last Exam: _____
- Injuries _____
- Cataracts

EAR, NOSE, THROAT, AND MOUTH

- Wear Hearing Aids
- Hearing Loss
- Ringing in Ears:
- Balance Disturbance (e.g. vertigo or spinning)
- Nasal Congestion
- Nasal Drainage
- Inability to Smell
- Date of Last Exam _____
- Ear Pain
- Ear Infections
- Left
- Right
- Both
- Sinus Problems
- Amount: _____ Color: _____
- Sore Throats
- Mouth Sores

CARDIOVASCULAR

- Chest Pain or Angina
- High Blood Pressure
- Irregular Pulse
- Swelling in Feet/Hands
- Mitral Valve Prolapse
- Date of Last EKG: _____
- High Cholesterol
- Heart Murmur
- Heart Attack

RESPIRATORY

- Asthma
- Emphysema
- Bronchitis
- Lung Cancer
- Chronic Cough
- Shortness of Breath
- Pneumonia
- Bloody Sputum

Date of last chest x-ray: _____

GASTROINTESTINAL

- Indigestion or Pain with Eating
- Vomiting
- Liver Disease
- Abdominal Pain
- Ulcers or Gastritis
- Reflux
- Nausea
- Blood in Vomit
- Jaundice
- Change in Bowel Habits
- Colon Cancer

GENITOURINARY

- Urinary Tract Infections
- Painful Urination
- Difficulty Starting Stream
- Incontinence
- Prostate Cancer
- Blood in Urine
- Difficulty Stopping Stream
- Kidney Stones
- Endometriosis
- Uterine or Cervical Cancer

MUSCULOSKELETAL

- Broken Bones (list) _____
- Back Pain
- Joint Pain/Swelling
- Fibromyalgia
- Osteoporosis
- Arthritis
- Arm Pain
- Leg Pain
- Neck Pain

INTEGUMENTARY

- Skin Disease
- Breast Pain, Tenderness, Swelling
- Nipple Discharge
- Skin Cancer

NEUROLOGICAL

- Fainting Spells
- History of Headaches
- Disorientation
- Inability to Concentrate
- Face Weakness
- Brain Tumors
- Aneurysms
- "Blacking Out"
- Seizures
- Problems with Memory
- Difficulty with Speech
- Double or Blurred Vision
- Coordination in Arms/Legs
- Stroke

PSYCHIATRIC

- Anxiety
- Other Psychiatric Disorder/Treatment _____
- Depression

ENDOCRINE

- Diabetes
- Thyroid Disease
- Increased Appetite
- Excessive Thirst or Urination
- Hormone Problems

HEMATOLOGIC/LYMPHATIC

- Anemia
- Persistent Swollen Glands or Lymph Nodes
- Bleeding Tendencies
- Hemophilia
- Blood Transfusion (list date) _____

My pain is: Continuous Intermittent

My pain has: Improved Remained the Same Gotten Worse Since Onset

If your pain was a "10" at its worst, and a "0" is no pain, what is it on average? _____

The above information is accurate to the best of my knowledge.

I have reviewed the above information with the patient.

Patient Signature

Date

Physician Signature

Date

Reviewed on: _____ Initials: _____