

Review of Systems

Patient Name: _____ Pt File# _____ Date: ___/___/___

Instructions: Please fill out all of the sections. If none of the conditions apply, select "NONE."

Constitutional:

- NONE
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:

- NONE
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eyes)
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose, and Throat:

- NONE
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infections
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (runny nose)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (ringing in the ears)
- TMJ Disorder

Cardiovascular:

- NONE
- Angina (chest pain or discomfort)
- Chest Pain
- Claudication (leg pain or achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying)
- Palpitations
- Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- Shortness of Breath
- Swelling of Legs
- Ulcers
- Varicose Veins

Gastrointestinal:

- NONE
- Abdominal pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (yellowing of skin)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (quality)
- Abnormal Stool color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:

- NONE
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:

- NONE
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:

- NONE
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Parasthesia (numbness, prickling, tingling)
- Rash
- History of Skin Disorder
- Skin Lesions or Ulcers
- Varicosities

Nervous System:

- NONE
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:

- NONE
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:

- NONE
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion
- Bruises Easily
- Fatigue
- Lymph Node Swelling

Psychological:

- NONE
- Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Changes

Female:

- NONE
- Birth Control Therapy
- Breast Lumps/Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

MALE:

- NONE
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above Review of Systems with the above named patient.

Doctor Signature Date