

# Review of Systems

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

Please explain any Yes answers in space provided

**Constitutional Symptoms**

Fever                    Y    N  
 Chills                    Y    N  
 Headache                Y    N  
 Other \_\_\_\_\_

**Eyes**

Blurred vision            Y    N  
 Double vision            Y    N  
 Pain                        Y    N  
 Other \_\_\_\_\_

**Allergic/Immunologic**

Hay Fever                Y    N  
 Drug allergies            Y    N  
 Other \_\_\_\_\_

**Neurological**

Tremors                    Y    N  
 Dizzy spells              Y    N  
 Numbness/tingling        Y    N  
 Other \_\_\_\_\_

**Endocrine**

Excessive thirst            Y    N  
 Too hot/cold              Y    N  
 Tired/sluggish            Y    N  
 Other \_\_\_\_\_

**Gastrointestinal**

Abdominal pain            Y    N  
 Nausea/vomiting            Y    N  
 Indigestion/heartburn    Y    N  
 Other \_\_\_\_\_

**Cardiovascular**

Chest pain                Y    N  
 Varicose veins            Y    N  
 High blood pressure        Y    N  
 Other \_\_\_\_\_

**Integumentary**

Skin rash                    Y    N  
 Boils                        Y    N  
 Persistent itch            Y    N  
 Other \_\_\_\_\_

**Musculoskeletal**

Joint pain                    Y    N  
 Neck pain                    Y    N  
 Back pain                    Y    N  
 Other \_\_\_\_\_

**Ear/Nose/Throat/Mouth**

Ear infection                Y    N  
 Sore throat                 Y    N  
 Sinus problems            Y    N  
 Other \_\_\_\_\_

**Genitourinary**

Urine retention             Y    N  
 Painful urination            Y    N  
 Urinary frequency         Y    N  
 Other \_\_\_\_\_

**Respiratory**

Wheezing                    Y    N  
 Frequent cough             Y    N  
 Shortness of breath        Y    N  
 Other \_\_\_\_\_

**Hematologic/Lymphatic**

Swollen glands              Y    N  
 Blood clotting problem    Y    N  
 Other \_\_\_\_\_

**Psychologic**

Are you generally satisfied with your life?    Y    N  
 Do you feel severely depressed?                Y    N  
 Have you considered suicide?                    Y    N  
 Other \_\_\_\_\_

**Physician use only: (Comments/Notes)**

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_