



Review of Systems

Patient Name: _____
Date of Birth: _____

Today's Date: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

General

Good general health lately no yes
Recent weight change no yes
Fever no yes
Fatigue no yes

Eyes and vision

Eye disease or injury no yes
Blurred or double vision no yes
Glaucoma no yes

Ears, nose, throat and mouth

Hearing loss no yes
Ringing in the ears no yes
Earaches no yes
Sinus problems no yes
Mouth sores no yes
Dental or chewing problems no yes
Dentures no yes

Heart trouble

Heart trouble no yes
Chest pains no yes
Sudden heartbeat changes no yes
Swelling of feet, ankles, hands no yes

Breathing trouble

Frequent coughing no yes
Spitting up blood no yes
Shortness of breath no yes
Asthma or wheezing no yes

Stomach trouble

Loss of appetite no yes
Change in bowel movements no yes
Nausea or vomiting no yes
Stomach pain no yes
Gastric Bypass or Lap Band no yes

WOMEN:

Last menstrual period? _____
Any menstrual problems? Yes _____ No _____
Number of pregnancies _____
Difficult pregnancy? Yes _____ No _____
Miscarriages? _____
Birth control method (if any)? _____
Hysterectomy? Yes _____ No _____
Breast pain/lump/discharge? Yes _____ No _____
Last mammogram? Date: _____

Joint trouble

Cold hands/feet no yes
Difficulty walking no yes
Muscle pain or cramps no yes

Neurologic trouble

Frequent or recurrent headaches no yes
Light headed or dizzy no yes
Convulsions or seizures no yes
Numbness or tingling sensations no yes
Tremors or shaking no yes
Involuntary movements no yes
Stroke no yes
Head injury no yes
Balance problems no yes

Hormone trouble

Thyroid disease no yes
Diabetes no yes
Excessive thirst or urination no yes
Heat or cold intolerance no yes
Change in hat or glove size no yes
Change in skin color no yes
Change in hair or nails no yes

Bleeding trouble

Slow to heal after cuts no yes
Easily bruising or bleeding no yes
Anemia no yes

Urination trouble

Frequent urination no yes
Burning or painful urination no yes
Blood in urine no yes

ACTIVITY: (CHECK ONE OR MORE BOXES)

- ☐ Occasional vigorous activity.
☐ Regular vigorous exercise.

MEN:

Prostate problems? Yes _____ No _____
Erectile problems? Yes _____ No _____
Vasectomy? Yes _____ No _____
Hormone Irregularities? Yes _____ No _____

Patient/ Gaurdian Signature _____ Date _____

Reviewed By _____ Date _____