Review of Systems

Please circle the answer!

	Y (now)	P (past)	N (never)
1.GENERAL			
Weight			
Weight one year ago			
Maximum weight			
When?			
Height			
Fatigue/weakness	Y	P	N
Fever/chills	Y	P	N
2.SKIN			
Rashes	Y	P	N
Eczema, hives	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Colour change	Y	P	N
Lumps	Y	P	N
Night sweats	Y	P	N
Dryness/moistness	Y	P	N
Temperature	Y	P	N
Nail changes	Y	P	N
Change in mole	Y	P	N
Skin cancer	Y	P	N
3.HEAD			
Headache	Y	P	N
Head injury	Y	P	N
Dizziness	Y	P	N
4.EYES			
Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing or dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Blurring	Y	P	N
Bothered by sun	Y	P	N
Itching	Y	P	N
Redness	Y	P	N
Discharge	Y	P	N
Blind spot	Y	P	N

	Y (now)	P (past)	N (never)
5.EARS			
Impaired hearing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
Discharge	Y	P	N
Infections	Y	P	N
Ringing in ears (tinnitus)	Y	P	N
6.NOSE and SINUSES			
Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay fever	Y	P	N
Sinus problems	Y	P	N
7.MOUTH and THROAT			
Frequent sore throat	Y	P	N
Sore tongue/mouth	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N
Loss of taste	Y	P	N
8.NECK			
Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain or stiffness	Y	P	N
9.CARDIOVASCULAR			
Heart disease	Y	P	N
Angina	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations, fluttering	Y	P	N
Cyanosis	Y	P	N
Past ECG	Y	P	N

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	Y (now)	P (past)	N (never)		Y (now)	P (past)	N (never)
10.RESPIRATORY				**12.URINARY**			
Cough	Y	P	N	Pain on urination	Y	P	N
Sputum	Y	P	N	Increased frequency	Y	P	N
Spitting up blood	Y	P	N	Frequency at night	Y	P	N
Wheezing	Y	P	N	Inability to hold urine	Y	P	N
Asthma	Y	P	N	Frequent infections	Y	P	N
Bronchitis	Y	P	N	Kidney stones	Y	P	N
Pneumonia	Y	P	N	Blood in urine	Y	P	N
Emphysema	Y	P	N	Urgency	Y	P	N
Difficulty breathing	Y	P	N	Hesitancy	Y	P	N
Pain on breathing	Y	P	N				
Shortness of Breath	Y	P	N	**13.BLOOD/LYMPHATIC**			
Shortness of Breath at night	Y	P	N	Anemia	Y	P	N
Shortness of Breath lying down	Y	P	N	Easy bleeding or bruising	Y	P	N
Tuberculosis	Y	P	N	Past transfusions	Y	P	N
Tuberculin Test	Y	P	N	Lymph node swelling	Y	P	N
Last Chest-ray	Y	P	N				
11.GASTROINTESTINAL				**14.PERIPHERAL VASCULAR**			
Trouble swallowing	Y	P	N	Deep leg pain	Y	P	N
Heartburn	Y	P	N	Cold hands/feet	Y	P	N
Change in thirst	Y	P	N	Varicose veins	Y	P	N
Change in appetite	Y	P	N	Thrombophlebitis	Y	P	N
Nausea	Y	P	N	Leg cramps	Y	P	N
Vomiting	Y	P	N	Extremity numbness	Y	P	N
Vomiting blood	Y	P	N	Extremity coldness	Y	P	N
Bowel movements - how often?				Extremity swelling	Y	P	N
Is this a change?	Y	P	N	Extremity ulcers	Y	P	N
Blood in stool	Y	P	N				
Belching or passing gas	Y	P	N	**15.MUSCULOSKELETAL**			
Jaundice (yellow skin)	Y	P	N	Joint pain or stiffness	Y	P	N
Liver disease	Y	P	N	Arthritis	Y	P	N
Gall bladder disease	Y	P	N	Broken bones	Y	P	N
Ulcer	Y	P	N	Muscle spasms or cramps	Y	P	N
Indigestion	Y	P	N	Weakness	Y	P	N
Constipation	Y	P	N	Joint swelling	Y	P	N
Diarrhea	Y	P	N	Backache	Y	P	N
Rectal bleeding	Y	P	N				
Hemorrhoids	Y	P	N	**16.ALLERGIC HISTORY**			
Black, tarry stool	Y	P	N	Drug sensitivity	Y	P	N
Abdominal pain	Y	P	N	Reaction to vaccine	Y	P	N
Food allergy	Y	P	N	Allergies? Please list			
Hernias	Y	P	N				

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	Y (now)	P (past)	N (never)
17.NEUROLOGIC			
Fainting	Y	P	N
Seizures/convulsions	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness or tingling	Y	P	N
Loss of memory	Y	P	N
Involuntary movement	Y	P	N
Loss of balance	Y	P	N
Speech problems	Y	P	N
18.ENDOCRINE			
Heat or cold intolerance	Y	P	N
Thyroid trouble	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Excessive urination	Y	P	N
Excessive sweating	Y	P	N
Diabetes	Y	P	N
Hypoglycemia	Y	P	N
Hormone therapy	Y	P	N
19.MALE REPRODUCTIVE			
Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N
Sexual orientation:			
Heterosexual	Y	P	N
Bisexual	Y	P	N
Homosexual	Y	P	N
23.HOBBIES/HABITS			
Please answer yes (Y) or no (N)			
		Y	N
Do you eat three meals daily?			
Do you awake rested?			
Do you sleep well?			
Do you average 6-8 hours of sleep?			
Do you enjoy your work?			
Do you watch television?			
How many hours/day?			
Do you exercise?			
What forms? How many times/week?			

	Y (now)	P (past)	N (never)
20.EMOTIONAL			
Depression	Y	P	N
Mood swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N
Phobias	Y	P	N
Alcohol/drug abuse	Y	P	N
Insomnia	Y	P	N
21.BREASTS			
Do you do self-exams?	Y	P	N
Lumps	Y	P	N
Pain (or tenderness)	Y	P	N
Nipple discharge	Y	P	N
22.FEMALE REPRODUCTIVE			
Age menses began			
Average number of days			
Length of cycle			
Bleeding between periods	Y	P	N
Are cycles regular?	Y	P	N
Pain during intercourse	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N
Birth control?	Y	P	N
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Difficulty conceiving	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Sexual orientation:			
Heterosexual	Y	P	N
Bisexual	Y	P	N
Homosexual	Y	P	N
Vaginal discharge	Y	P	N
Vaginal itching	Y	P	N
Last menstrual period			
Last PAP - (date)			
		Y	N
Have you been treated for drug dependence?			
Do you use recreational drugs?			

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