REVIEW OF SYSTEMS FORM

NAME: _____ DATE: _____

Do you or have you had any problems related to the following systems? Circle the appropriate response.

	(Current)	(Past)	Explain / give details
Family History			
Diabetes	C	P	_____
Thyroid disease	C	P	_____
Muscle / joint disease	C	P	_____
Cancer	C	P	_____
Inflammatory arthritis	C	P	_____
Autoimmune disorder	C	P	_____
Other	C	P	_____
General History			
Height Change	C	P	_____
Weight Change	C	P	_____
Fever / chills	C	P	_____
Night sweats	C	P	_____
Auto-immune disorder	C	P	_____
Malaise / fatigue	C	P	_____
Weakness	C	P	_____
Cardiovascular System			
Shortness of breath	C	P	_____
Chest discomfort	C	P	_____
Calf pain	C	P	_____
High blood pressure	C	P	_____
Respiratory System			
Difficulty in breathing	C	P	_____
Cough	C	P	_____
Blood in sputum	C	P	_____
Wheezing / asthma	C	P	_____
Exposure to chemical / asbestos	C	P	_____
Lung Infection / disease	C	P	_____
Skin / Hair / Nails			
Change in skin	C	P	_____
Rashes / itching	C	P	_____
Skin growths / lesions / cancer	C	P	_____
Change in hair quality / growth	C	P	_____
Change in nails (finger / toes)	C	P	_____
Dry skin	C	P	_____
Endocrine System			
Heat / cold intolerance	C	P	_____
Neck Surgery / Irradiation	C	P	_____

NAME: _____ DATE: _____

Eyes / Ears / Nose / Throat

Blurred / double vision	C	P	_____
Difficulty hearing / deaf	C	P	_____
Ringing in ears / dizziness	C	P	_____
Ear pain / growth / discharge	C	P	_____
Nose bleeds	C	P	_____
Change in ability to smell	C	P	_____
Nose pain / growth / discharge	C	P	_____
Sinusitis	C	P	_____

Gastrointestinal System

Change in appetite / food intolerance	C	P	_____
Nausea / vomiting	C	P	_____
Indigestion / heartburn	C	P	_____
Abdominal pain / swelling / gas	C	P	_____
Change in stool / color / etc.	C	P	_____
Diarrhea / constipation	C	P	_____
Hemorrhoids	C	P	_____
Gallbladder disease	C	P	_____
Pancreatitis	C	P	_____

Breast

Pain / tenderness	C	P	_____
Change in color / size / shape	C	P	_____
Nipple discharge	C	P	_____

Urinary System

Frequent urination	C	P	_____
Pain on urination	C	P	_____
Change in urine / color	C	P	_____
Difficulty starting / holding urine	C	P	_____
Discharge	C	P	_____
Flank / kidney / pelvic pain	C	P	_____
Urinary tract infections	C	P	_____
Night urination (# of times / night)	C	P	_____

Neurologic System

Headaches	C	P	_____
Seizures / ticks / spasm / tremor	C	P	_____
Weakness	C	P	_____
Numbness / tingling	C	P	_____
Dizziness	C	P	_____

Psychological History

Anxiety / nervousness	C	P	_____
Psychologic diagnoses	C	P	_____