PATIENT REVIEW OF SYSTEMS FORM

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1. GENERAL				Responses and Comments
Weight				
Weight 1 year ago				
Maximum weight				
When?				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. SKIN				Responses and Comments
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Color 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				Responses and Comments
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				Responses and Comments
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	

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5. EARS				Responses and Comments
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. NOSE AND SINUSES				Responses and Comments
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				Responses and Comments
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				Responses and Comments
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter	Y	P	N	
Pain or stiffness	Y	P	N	
Decreased range of motion	Y	P	N	

9. RESPIRATORY				Responses and Comments
Cough	Y	P	N	
Sputum	Y	P	N	
Spitting up blood	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on breathing	Y	P	N	
Shortness of breath	Y	P	N	

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Shortness of breath at night	Y	P	N	
Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest X-ray				

10. CARDIOVASCULAR				**Responses and Comments**
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Low blood pressure	Y	P	N	
Dizziness upon standing or bending over	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	
Other heart tests?				

11. BREASTS				**Responses and Comments**
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain or tenderness	Y	P	N	
Nipple discharge	Y	P	N	

12. GASTROINTESTINAL				**Responses and Comments**
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements - how often?				
Is this a change?	Y	P	N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall bladder disease	Y	P	N	
Ulcer	Y	P	N	

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Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

13. URINARY				**Responses and Comments**
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

14. MALE REPRODUCTIVE				**Responses and Comments**
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	

15. FEMALE REPRODUCTIVE				**Responses and Comments**
Age menses began				
Age menopause began				
Systems related to menopause				
Menses - average number of days				
Length of cycle				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse				
Painful menses	Y	P	N	
Excessive menstrual flow	Y	P	N	
PMS	Y	P	N	
Birth control	Y	P	N	
What method/type/brand?				

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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**	
Last menstrual period	**Y**	**P**	**N**	
Vaginal discharge	**Y**	**P**	**N**	
Vaginal itching	**Y**	**P**	**N**	
Date of last pap				

16. MUSCULOSKELETAL				**Responses and Comments**
Joint pain or stiffness	**Y**	**P**	**N**	
Arthritis	**Y**	**P**	**N**	
Broken bones	**Y**	**P**	**N**	
Muscle spasms or cramps	**Y**	**P**	**N**	
Weakness	**Y**	**P**	**N**	
Joint swelling	**Y**	**P**	**N**	
Backache	**Y**	**P**	**N**	

17. PERIPHERAL VASCULAR				**Responses and Comments**
Deep leg pain	**Y**	**P**	**N**	
Cold hands/feet	**Y**	**P**	**N**	
Varicose veins	**Y**	**P**	**N**	
Thrombophlebitis	**Y**	**P**	**N**	
Leg cramps	**Y**	**P**	**N**	
Extremity numbness	**Y**	**P**	**N**	
Extremity coldness	**Y**	**P**	**N**	
Extremity swelling	**Y**	**P**	**N**	
Extremity ulcers	**Y**	**P**	**N**	

18. NEUROLOGIC				**Responses and Comments**
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**	

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19. ENDOCRINE				Responses and Comments
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	

20. BLOOD/LYMPHATIC				Responses and Comments
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

21. ALLERGIC HISTORY				Responses and Comments
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

22. EMOTIONAL				Responses and Comments
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	

23. HOBBIES & HABITS (Please circle Y (yes) or N (no)				Responses and Comments
Do you eat three meals daily?	Y		N	
Do you consume water daily?	Y		N	
If yes, how many cups per day?	Y		N	
Do you awake rested?	Y		N	
Do you sleep well?	Y		N	
Do you average 6 to 8 hours sleep?	Y		N	
Do you enjoy your work?	Y		N	
Do you watch television?	Y		N	
If yes, how many hours per day?	Y		N	
What are your main interests & hobbies?				

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Do you read?	**Y**		**N**	
Do you exercise?	**Y**		**N**	
If yes, what form(s) of exercise?	**Y**		**N**	
How many times per week?	**Y**		**N**	
Do you take vacations?	**Y**		**N**	
History of cigarette smoking?	**Y**		**N**	
If yes, when and how much?				
History of recreational drug use?	**Y**		**N**	
If yes, when and how often?	**Y**		**N**	
How often do you consume alcoholic beverages?				