

Review of Systems

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

Constitutional Symptoms

Fever Y N Headache Y N

Chills Y N Other _____

Eyes

Blurred Vision Y N Double Vision Y N

Pain Y N Other _____

Ear/Nose/Throat/Mouth

Ear infection Y N Sinus problems Y N

Sore throat Y N Other _____

Respiratory

Wheezing Y N Shortness of breath Y N

Frequent cough Y N Other _____

Gastrointestinal

Abdominal Pain Y N Indigestion/Heartburn Y N

Nausea/Vomiting Y N Other _____

Genitourinary

Urine retention Y N Urinary frequency Y N

Painful urination Y N Other _____

Musculoskeletal

Joint pain Y N Back pain Y N

Neck pain Y N Other _____

Integumentary

Skin rash Y N Boils Y N

Persistent itching Y N Other _____

Neurological

Tremors Y N Numbness/tingling Y N

Dizzy spells Y N Other _____

Endocrine

Excessive thirst Y N Tired/sluggish Y N

Too hot/cold Y N Other _____

Cardiovascular

Chest Pains Y N Varicose veins Y N

High blood Pressure Y N Other _____

Hematologic/Lymphatic

Swollen glands Y N Blood clotting problem Y N

Other _____

Allergic/Immunologic

Hay Fever Y N Drug allergies Y N

Other _____

Psychologic

Are you generally satisfied with you life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Other _____

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

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

Physician: _____

Signature: _____

Date: ____/____/____