

NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in space provided

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes

Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic

Hay Fever Y N
Drug allergies Y N
Other _____

Neurological

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular

Chest Pain Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Integumentary

Skin rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal

Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Ear/Nose/Throat/Mouth

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Other _____

Genitourinary

Urine retention Y N
Painful urination Y N
Urine frequency Y N
Other _____

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other _____

Psychologic

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _____