REVIEW OF SYSTEMS FORM NAME: _____ DATE_____ ID_____

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

	(Current)	(Past)	**Explain/give details**
General History			
Height Change	C	P	_____
Weight Change	C	P	_____
Fever/chills	C	P	_____
Night sweats	C	P	_____
Allergies	C	P	_____
Anemia	C	P	_____
Bleeding/bruising	C	P	_____
Malaise/fatigue	C	P	_____
Weakness	C	P	_____
Cancer	C	P	_____
Family History			
Diabetes	C	P	_____
Thyroid disease	C	P	_____
Tuberculosis	C	P	_____
Kidney disease	C	P	_____
High blood pressure	C	P	_____
Heart disease/stroke	C	P	_____
Muscle/joint disease	C	P	_____
Cancer	C	P	_____
Inflammatory arthritis	C	P	_____
Autoimmune disorder	C	P	_____
Cardiovascular System			
Shortness of breath	C	P	_____
Chest discomfort	C	P	_____
Calf pain	C	P	_____
High blood pressure	C	P	_____
Heart disease	C	P	_____
Rheumatic Fever	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	_____
Cigarette/cigar/pipe/chew	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/toe)	C	P	_____
Endocrine System			
Heat/cold intolerance	C	P	_____
Thyroid Problems	C	P	_____
Diabetes	C	P	_____
Neck Surgery/Irradiation	C	P	_____
Stress	C	P	_____

REVIEW OF SYSTEMS FORM NAME: _____ DATE_____ ID_____

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 tolerance	C	P	_____
Nausea/vomiting	C	P	_____
Vomiting of blood	C	P	_____
Peptic ulcer	C	P	_____
Indigestion/heartburn	C	P	_____
Abdominal pain/swelling/gas	C	P	_____
Change in stool/color/etc.	C	P	_____
Diarrhea/constipation	C	P	_____
Hernia	C	P	_____
Hemorrhoids	C	P	_____
Gallbladder disease	C	P	_____
Pancreatitis	C	P	_____

Breast

Bumps/lumps/dimples	C	P	_____
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	_____

Reproductive System

Genital lesions/sores/mass pain	C	P	_____
Sexually transmitted infection	C	P	_____
Birth control (method)	C	P	_____

Female Patients

1st period_____age:_____	C	P	_____
Flow: Scant/moderate/heavy	C	P	_____
____Days in cycle	C	P	_____
PMS symptoms	C	P	_____
First date of last cycle_____	C	P	_____
Date of last Pap smear	C	P	_____
Menopause bleeding/spotting	C	P	_____
Post menopause bleeding	C	P	_____
___# pregnancies___# children	C	P	_____

REVIEW OF SYSTEMS FORM NAME: _____ DATE_____ ID_____

Neurologic System

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

Musculoskeletal System

Joint pain/swelling	C	P	_____
Muscle cramps	C	P	_____
Muscle weakness/wasting	C	P	_____
Neck pain	C	P	_____
Back pain	C	P	_____
Arm pain	C	P	_____
Leg pain	C	P	_____
Fractures/dislocations	C	P	_____
Sprains/strains	C	P	_____
Arthritis	C	P	_____
Auto-immune disorder	C	P	_____
Other accident/injury/disability	C	P	_____

Surgical History

Spinal Surgery	Yes	No_____
Neck Surgery	Yes	No_____
Joint Replacement	Yes	No_____
Other Joint Surgery	Yes	No_____
Any other Surgery	Yes	No_____

Psychological History

Anxiety/nervousness	C	P	_____
Psychologic diagnoses	C	P	_____

Medications/Supplements

Allergies to medications	C	P	_____
Non-prescription medications	C	P	_____

_____

_____

Vitamin or Supplement Use	C	P	_____

_____

_____

List prescription medications (continue on back if needed) **Purpose for the medication**

_____ _____

_____ _____

_____ _____

_____ _____

I do hereby attest that this information is true, accurate and complete to the best of my knowledge.

Patient Signature_____ Date:_____

Reviewed By:

Intern Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

Rev 01/31/14