Name _____ Date _____

REVIEW OF SYSTEMS

DOB _____

GENERAL	YES	NO
Recent fever		
Anemia		
Night sweats		
Swollen glands		
Undue tiredness		
Unexplained weight loss		
Weight gain		
HEAD		
Tension or frequent headaches		
Fainting spells		
Hair change		
Convulsions		
EYES		
Glasses		
Discharge		
Pain		
Blurred vision		
Glaucoma		
Cataracts		
NECK		
Goiter		
Thyroid trouble		
Stiffness		
BREASTS		
Lumps		
Discharge		
HEART		
Chest pain or pressure on exertion		
Shortness of breath:		
On exertion		
At rest		
Use more than one pillow to sleep		
Swelling of ankles		
Heart palpitations, pounding, or skipping		
High blood pressure		
Heart murmur		
SKIN		
Rashes		
Lumps		
Easy bruising		
Eczema		
Psoriasis		
EXTREMITIES		
Joint pain or swelling		
Varicose veins		
Paralysis		
Weakness		
Numbness		
Pain on walking		
Back trouble		

GASTROINTESTINAL	YES	NO
Loss of appetite		
Indigestion		
Heartburn		
Nausea		
Vomiting		
Vomiting blood		
Diarrhea		
Constipation		
Blood in stool		
Pale stools		
Abdominal pain □ Upper □ Lower		
Gall bladder problems		
Food intolerance		
What foods?		
NOSE		
Drainage		
Bleeding		
Snoring		
MOUTH		
Dentures		
Sore throat		
Swallowing difficulty		
Hoarseness		
EARS		
Hearing loss		
Ringing		
Discharge		
Pain		
CHEST		
Cough		
Phlegm □ Colored □ Clear		
Pain in any part of chest/upper back		
Blood in mucus		
Wheezing		
Unable to lay flat		
GENITO-URINARY		
Pain or burning on passing water		
Frequency		
Blood in urine		
Trouble starting urine		
Up at night to urinate		
How many times?		
Leakage of urine		
Pain or trouble with sexual intercourse		
NERVOUS SYSTEM		
Depression		
Nervousness		
Trouble sleeping		
Excessive worry		
Suicidal thoughts		