Name_____ Birthdate_____ Today's date_____

Review of Systems

General

Weight	_____
Weight 1 year ago	_____
Maximum weight	_____
Maximum when?	_____
Height	_____
Date of last Physical	_____
Fatigue	Y P N
Night Sweats	Y P N

Skin

Rashes	Y P N
Inflammation	Y P N
Infection	Y P N
Growths	Y P N
Change in hair/nails	Y P N

Head

Headache	Y P N
Head Injury	Y P N

Eyes

Impaired vision	Y P N
Eye Pain	Y P N
Tearing or dryness	Y P N
Double Vision	Y P N

Ears

Impaired hearing	Y P N
Ringing	Y P N
Earache/itch	Y P N
Dizziness	Y P N

Nose and Sinuses

Frequent Colds	Y P N
Nose bleeds	Y P N
Stuffiness	Y P N
Sinus problems	Y P N
Post nasal drip	Y P N

Mouth & Throat

Frequent sore throat	Y P N
Sore tongue	Y P N
Sores-mouth/lips	Y P N
Gum problems	Y P N
Hoarseness	Y P N
Dental Problems	Y P N

Neck

Swollen glands	Y P N
Pain or stiffness	Y P N

Blood

Anemia	Y P N
Easy bleeding or bruising	Y P N

Respiratory

Cough	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
" While laying down	Y	P	N
" At night	Y	P	N
Positive TB test ever?	Y	P	N

Circulation

Deep leg pain	Y	P	N
Cold hands & feet	Y	P	N
Varicose veins	Y	P	N

Neurologic

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Loss of memory	Y	P	N

Endocrine

Thyroid problem	Y	P	N
Heat /cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

Breasts

Regular self exams	Y	P	N
Lumps	Y	P	N
Pain or tenderness	Y	P	N
Nipple discharge	Y	P	N

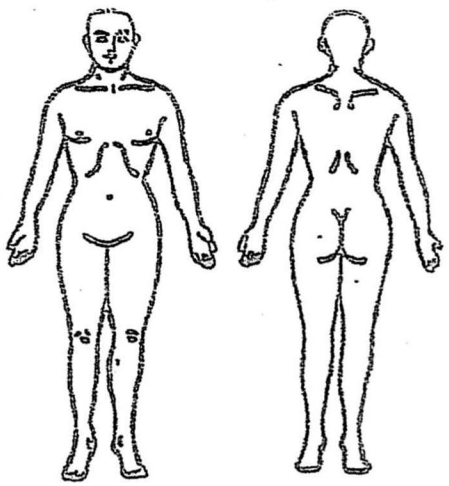
Emotional

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N
Weakness	Y	P	N

Musculoskeletal

Joint pain or Stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasms or Cramps	Y	P	N
Weakness	Y	P	N

Indicate on diagram any problem areas:



Name_____ Birthdate_____ Today's date_____

Review of Systems

Female Reproduction

Age menses began _____
# of days last menstrual flow_____
Length of complete cycle _____
Bleeding between periods Y P N
Regular menstrual cycles Y P N
Pain during intercourse Y P N
Cramps Y P N
Abnormal vaginal discharge Y P N
Excessive flow Y P N
PMS Y P N
Date of last PAP _____
Abnormal PAP Y P N
Date of last period _____
pregnancies _____
live births _____
miscarriages _____
abortions _____
Birth Control Y P N
What type _____
Difficulty conceiving Y P N
Menopausal Symptoms Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Venereal disease Y P N

Male Reproduction

Hernias Y P N
Testicular masses Y P N
Are you sexually active? Y P N
Sexual difficulties Y P N
Prostate problems Y P N
Venereal disease Y P N
Discharge or sores Y P N
Difficulty starting or stopping urination Y P N
Birth Control Y P N
What type _____