

Name \_\_\_\_\_

## 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
Urinary 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 _____		

Physician use only: (Comments/Notes)

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

Physician: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_