



Name _____ DOB _____ Age _____ Today's Date _____

Review of Systems

Please indicate YES or NO for each of the following conditions

1. General

Good general health lately No Yes
 Fatigue No Yes
 Headaches No Yes

2. Eyes

Blurred vision No Yes
 Glaucoma No Yes

3. Ears/Nose/Throat

Hearing loss No Yes
 Chronic sinus problem No Yes
 Frequent nose bleeds No Yes
 Sore throat No Yes
 Too hot/too cold No Yes

4. Cardiovascular

Chest pain No Yes
 Palpitations No Yes
 Shortness of breath No Yes
 Swelling of feet No Yes

5. Respiratory

Chronic or frequent cough No Yes
 Spitting up blood No Yes
 Wheezing No Yes

6. Gastrointestinal

Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Frequent constipation No Yes
 Rectal bleeding/blood in stool No Yes
 Heartburn No Yes

7. Musculoskeletal

Joint Pain No Yes
 Muscle cramps No Yes
 Cold extremities No Yes
 Neck pain No Yes

8. Neurologic

Seizures No Yes
 Stroke No Yes
 Lightheaded No Yes
 Numbness/tingling No Yes

9. Psychiatric

Depression No Yes
 Trouble sleeping No Yes
 Nervousness/ anxiety No Yes

10. Endocrine

Excessive thirst No Yes
 Tired/sluggish No Yes

11. Blood/Lymphatic

Swollen glands No Yes
 Bruising tendency No Yes
 Anemia No Yes

12. Skin

Rash No Yes
 Varicose veins No Yes

13. Genitourinary

Leakage of urine No Yes
 Frequency of urination No Yes
 Painful urination No Yes
 Irregular periods No Yes
 Very heavy periods No Yes
 Very painful periods No Yes
 Painful intercourse No Yes

14. Allergic/Immunologic

Hayfever No Yes

