

PATIENT NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Please circle the appropriate answers

GENERAL

Recent weight change	Yes	No
If so, how much _____ lbs	Gain /	Loss
Weakness / Fatigue	Yes	No

SKIN / BREAST

Easy Bruising	Yes	No
History of breast cancer	Yes	No

LYMPH

Enlarged node	Yes	No
Gland swelling	Yes	No

ENDOCRINE

Diabetes	Yes	No
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HEAD/EYES/EARS/NOSE/THROAT

Stroke history	Yes	No
Sinus trouble	Yes	No
Eyeglasses / Contact lenses	Yes	No

BLOOD

Abnormal bleeding / bruising	Yes	No
Anemia	Yes	No
Transfusions	Yes	No
History of hemophilia (free bleeder)	Yes	No
History of sickle cell	Yes	No
Low white cell or platelet count	Yes	No

RESPIRATORY

Shortness of breath	Yes	No
Asthma history	Yes	No
Pneumonia history	Yes	No
History/Exposure of Tuberculosis	Yes	No
History of respiratory infections	Yes	No
if yes, give frequency: _____		

CARDIAC

Chest pain / discomfort	Yes	No
Irregular heartbeat	Yes	No
Heart trouble	Yes	No
High blood pressure	Yes	No
Rheumatic heart disease	Yes	No
Heart murmur	Yes	No
Palpitation	Yes	No
Fainting spells	Yes	No
Swelling of ankles	Yes	No

DIGESTIVE SYSTEM

Abdominal pain (last 6 mths)	Yes	No
Abd. swelling/bloating (last 6 mths)	Yes	No
Indigestion / heartburn	Yes	No
Nausea or vomiting	Yes	No
Diarrhea (last 6 mths)	Yes	No
Decreased appetite	Yes	No
"Yellow Jaundice"/Hepatitis	Yes	No
Change in bowel habits (last 6 mths)	Yes	No
Red blood in stool (last 6 mths)	Yes	No
Black stools (last 6 mths)	Yes	No
Light, clay colored stool (last 6 mths)	Yes	No
Constipation (last 6 mths)	Yes	No
Ulcer disease history	Yes	No
Pancreatitis history	Yes	No

GENITOURINARY SYSTEM

History of kidney disease/stones	Yes	No
Any problems with urination	Yes	No
Hemorrhoids or anal itching	Yes	No
Number of pregnancies: _____		
Number of children: _____		

EXTREMITIES

Swelling	Yes	No
Numbness	Yes	No
Joint pain or stiffness	Yes	No
History of gout	Yes	No
Significant injuries: _____		

NERVOUSNESS / STRESS

History of "nervous" problems	Yes	No
History of anxiety or depression	Yes	No

Doctors Initials: _____
Date of Review: _____