Patient: _____ Date: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Boils	Y	N
Headache	Y	N	Persistent itch	Y	N
Other			Other		
Eyes			**Muscoloskeletal**		
Blurred vision	Y	N	Join pain	Y	N
Double vision	Y	N	Neck pain	Y	N
Pain	Y	N	Back pain	Y	N
Other			Other		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Y	N	Ear infection	Y	N
Drug Allergies	Y	N	Sore throat	Y	N
Other	Y	N	Sinus problem	Y	N
			Other		
Neurological			**Genitourinary**		
Tremors	Y	N	Urine retention	Y	N
Dizzy spells	Y	N	Painful urination	Y	N
Numbness/tingling	Y	N	Urinary frequency	Y	N
Other			Other		
Endocrine			**Respiratory**		
Excessive thirst	Y	N	Wheezing	Y	N
Too hot/cold	Y	N	Frequent cough	Y	N
Tired/sluggish	Y	N	Shortness of breath	Y	N
Other			Other		
Gastrointestinal			**Hematologic/Lymphatic**		
Abdominal pain	Y	N	Swollen glands	Y	N
Nausea/vomiting	Y	N	Blood clotting problem	Y	N
Indigestion/heartburn	Y	N	Other		
Other					
Cardiovascular			**Psychologic**		
			Are you unhappy with your life?	Y	N
Chest pain	Y	N	Do you feel severely depressed?	Y	N
Varicose veins	Y	N	Have you considered suicide?	Y	N
High blood pressure	Y	N	Other		
Other					