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 the 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/Lympathic:

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: _____/_____/_____