REVIEW OF SYSTEMS

NAME: ____ **DATE**: _________________

Please circle any of the following conditions if they are currently significant:

GENERAL: fever - fatigue - changes in hair - chills - unexplained weight loss

EYES: eye pain - double vision - glaucoma - discharge

EAR, NOSE, MOUTH, THROAT: *ear* - pain - drainage - hearing aid - ringing; *nose* -congestion -recurrent nose bleeds - sinus infection; *throat and mouth* - throat pain - ulcers/sores - difficulty swallowing

CARDIOVASCULAR: chest pain - heart attack - fast/slow heart beat - heart murmur - leg swelling - fainting - shortness of breath during the night - pain in calves/thighs when walking

RESPIRATORY: diarrhea - constipation - stomach pain - stomach swelling - vomiting - indigestion - nausea - black stools - bright red stools - hemorrhoids - change in bowel habits

GENITOURINARY: pain or burning during urination - blood in urine - urine stream slow to start incontinence -

How many times do you get up to urinate nightly? _________________________

(Women Only) last menstrual period: _________________________ - vaginal discharge -

vaginal bleeding after menopause - date last pap smear: ___________________________

MUSCULOSKELETAL: extreme backache - pain/numbness of arms or legs - joint pain - joint swelling

SKIN: itching - lesions - change in moles - breast mass - do not perform self breast exam - nipple discharge

date last mammogram: ___________________________

NEUROLOGICAL: temporary loss of vision/slurred speech - seizures - loss of balance - stroke - loss of coordination

PSYCHIATRIC: depression - anxiety - mood swings - loss of appetite - suicidal thoughts - sleep disturbance

ENDOCRINE: excessive thirst - excessive hunger - intolerance of heat and cold

HEMATOLOGICAL/LYMPHATIC: swollen lymph glands - easy bruising - bleeding from gums

ALLERGIC/IMMUNOLOGIC: drug allergies: ____

seasonal allergies - food allergies - insect allergies - steroid usage during past year

MD initials ______________

Date ____________________