

# 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 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/Lymphatic

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: \_\_\_\_/\_\_\_\_/\_\_\_\_