REVIEW OF SYSTEMS

Name_____ **Date**_____

Height_____ **AGE**_____ **Weight**_____

CONSTITUTIONAL SYSTEMS

Weight change	Y N
Loss of Appetite	Y N
Fever	Y N
Chills	Y N
Weakness	Y N
Bleeding Problems	Y N
Fatigue	Y N

CARDIOVASCULAR

Shortness of Breath	Y N
Chest Pain	Y N
Murmurs	Y N
Palpitations	Y N
Dizziness	Y N
Edema	Y N
Angina	Y N
Arrhythmia	Y N
Endocarditis	Y N
Heart Attack	Y N
Heart Valve Replacement	Y N
High Blood Pressure	Y N
Mitral Valve Prolapse	Y N

RESPIRATORY

Asthma	Y N
Chronic Cough	Y N
Emphysema/Bronchitis	Y N
Shortness of Breath	Y N
Tuberculosis	Y N
Ringing in ears	Y N
Voice Change	Y N
Hearing Loss	Y N

GASTROINTESTINAL

Heartburn	Y N
Nausea	Y N
Vomiting	Y N
Abdominal Pain	Y N
Change in bowel habits	Y N
Blood in Stool	Y N

ENDOCRINE

Diabetes	Y N
Pituitary	Y N
Thyroid Disease	Y N
Excessive Sweating	Y N
Sleep Disturbance	Y N

MUSCULOSKELETAL

Joint Stiffness	Y N
Joint Pain	Y N
Joint Swelling	Y N
Leg cramps	Y N
Sciatica	Y N

PHARMACEUTICAL

Anti-Inflammatories	Y N
Aspirin Products	Y N
Coumadin	Y N
Glucophage	Y N
Nitrates	Y N
Persantine	Y N
Plavix	Y N

I have reviewed the above:

Physicians' signature:_____

DERMATOLOGY

Dry/Sensitive Skin	Y N
Persistent Itching	Y N
Excessive Perspiration	Y N
Rash	Y N
Bruising	Y N
Moles	Y N
Skin Cancer	Y N

NEUROLOGICAL

Headache	Y N
Tingling/Numbness	Y N
Seizures	Y N
Dizziness	Y N
Gait Abnormality	Y N

INCONTINENCE

Feces	Y N
Urine	Y N

HEMATOLOGICAL

Easy Bleeding	Y N
Bruising	Y N
Hepatitis	Y N
HIV (AIDS)	Y N
IV Drug use	Y N

PSYCHOLOGICAL

Depression	Y N
Tension/Stress	Y N
Suicidal Ideation	Y N
ADHD	Y N
Eating Disorder	Y N
Anxiety	Y N

STERIOD USE Y N

Any fecal soiling?	Y N
Having difficulty evacuating?	Y N

Office use only: Temp: _____ Pulse_____ RR_____ BP_____

I have reviewed the above:

Physicians' signature: _____