
REVIEW OF SYSTEMS

DATE: _____

NAME: _____

DOB: _____

ALLERGIES TO FOOD/MEDICATIONS:

Have you had any of the following symptoms or difficulties in the past year?
PLEASE CIRCLE EITHER YES OR NO TO EACH QUESTION

CARDIOVASCULAR:

YES NO Chest Pain
YES NO Recent Heart Problems

CONSTITUTIONAL:

YES NO Fever
YES NO Weight Loss
YES NO Change in Appetite

ENT:

YES NO Hearing Problems
YES NO Nosebleeds
YES NO Sinus Infections
YES NO Recent Sore Throat

EYES:

YES NO Visual Problems or Changes

GASTROINTESTINAL:

YES NO Nausea, Vomiting
YES NO Change in Bowel Habits
YES NO Blood in Stools
YES NO Abdominal Pain

GENITOURINARY:

YES NO Pain with Urination
YES NO Blood in Urine
YES NO Increased Frequency of Urination

GYN (FEMALES ONLY):

YES NO Change in Menstrual Cycle

HEMATOLOGIC:

YES NO Bleeding Problems
Lymphatic - Lumps in Neck, Groin

MUSCULOSKELETAL:

YES NO Aches, Weakness, Swelling

RESPIRATORY:

YES NO Shortness of Breath
YES NO Coughing
YES NO Recent Pneumonia

SKIN:

YES NO Itching, Rashes, New Moles

SOCIAL HISTORY:

Do you you smoke? YES NO

Consumption of alcohol?

DAILY WEEKLY SELDOM NEVER

OCCUPATION: _____

FOR OFFICE USE ONLY

HT: _____

WT: _____

BP: _____