Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N	Headache	Y	N
Chills	Y	N	Other _____		

Eyes

Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other _____		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N	Sinus Problems	Y	N
Sore throat	Y	N	Other _____		

Respiratory

Wheezing	Y	N	Shortness of breath	Y	N
Frequent Cough	Y	N	Other _____		

Gastrointestinal

Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other _____		

Genitourinary

Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other _____		

Musculoskeletal

Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N	Other _____		

Integumentary

Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N	Other _____		

Neurological

Tremors	Y	N	Numbness/tingling	Y	N
Dizzy spells	Y	N	Other _____		

Endocrine

Excessive thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other _____		

Cardiovascular

Chest pains	Y	N	Varicose veins	Y	N
High blood pressure	Y	N	Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N	Blood clotting problem	Y	N
Other _____					

Allergic/Immunologic

Hay Fever	Y	N	Drug Allergies	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 _____		

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

# Answer Service	Level of
0 – 1	1 or 2
2 – 9	3
10+	4 or 5

Physician: _____ Date: _____/_____/_____