

REVIEW OF SYSTEMS

Provider# _____ Account# _____

Name _____ DOB _____ Date _____

(Check below if you have experienced any recent problems in the following categories)

General: Unusual Weight Loss/Gain
 Fever

Eyes: Cataracts Blurred vision Double vision
 Glaucoma Eye Pain

Ears, Nose, Throat: Hearing Loss Difficulty chewing or swallowing Sinusitis Ringing in ears
CV: Chest pain History of heart attack
 Palpitations

Resp: Shortness of breath Asthma Productive cough TB
GI: Diarrhea Bloody stools Constipation Abdominal pain Bleeding ulcer Nausea/Vomiting
GU: Loss of bladder control Blood in urine Burning urination

Musculoskeletal: Joint Pain /Arthritis Muscle pain
Skin: History of skin cancer

Menstrual/Pregnancy/Menopause: History of menstrual irregularities, miscarriages or menopause

Estrogens: Hormone replacement therapy/Birth Control

Breast Disease: History of breast disease

Prostate/Sexual Functions: History of nocturnal urination or impotence

Neurological: Headaches Dizziness Blackouts Convulsions Confusion Memory problems Blurred vision
 Change in voice Numbness Clumsy Loss of balance Shaking, tremor or jerking Weakness

Psychological: Depression Anxiety Insomnia

Endocrine: Thyroid Disease Diabetes

Hematologic: History of free bleeding/easy bruising Anemia Prior blood transfusions

Allergic/Immuno: History of allergy to Ragweed, etc. History of easy infections

Other medical history information: _____

Physician use only: Level 1 2 3 4 5