

Review of Systems

NAME _____ DATE _____ AGE _____

(PLEASE USE REVERSE SIDE OF PAGE IF NECESSARY)

CONSTITUTIONAL:	YES	NO	WOMEN'S BREASTS:	YES	NO
Are you tired all the time?			Did your breasts develop normally?		
Do you run elevated temperatures			Are your breasts equal size?		
Have you lost weight? # of lbs _____			Have you had lumps in your breasts?		
Have you gained weight? # of lbs _____			Have you had surgery on your breasts?		
			If yes, Benign?		
EYES:			If yes, Malignant?		
Do you have blurred vision?			Have you had discharge from your nipples?		
Are you color blind?					
Do you wear contacts?			RESPIRATORY:		
Do you have double vision?			Do you have allergies?		
Do you wear glasses for distance?			Have you had asthma?		
Do you wear glasses for reading?			Do you still have asthma?		
Are you crossed-eyed?			Have you had bronchitis?		
Have you had injury to your eye?			Do you still have bronchitis?		
			Do you have emphysema?		
EARS:			Do family members have lung problems?		
Have you acquired deafness?			If yes, please list them: _____		
Are you deaf since birth?			_____		
Do you have discharge from your ear?			Do you have a chronic cough?		
Do you have frequent infections?			Do you have a productive cough?		
Have you had mastoiditis?			Have you coughed up blood?		
Have you had ear surgery?			Are you short of breath?		
Do your ears hurt?			Do you have trouble breathing lying down?		
Are you dizzy or have vertigo?			Do you sweat in bed at night?		
			Do you have a pain in your chest breathing?		
NOSE:			Have you ever had pneumonia?		
Do you have a frequent runny nose?			Do you use tobacco?		
Do you have nosebleeds?			If yes, Cigarettes?		
Do you have nasal polyps?			Pipe?		
Does your nose itch?			Chew tobacco?		
Do you have sneezing attacks?			Chews cigars?		
			Dips tobacco?		
MOUTH:			Dips snuff?		
Do you have mercury fillings?			Total time _____		
Do you have unfilled cavities?			When quit? _____		
Do you have any root canals?					
Do you have pain in your teeth?			CARDIOVASCULAR:		
Do you have gum disease?			Do you have pain in your chest?		
Do you have funny tastes in your mouth?			Do you have tight sensations in your chest?		
Do you have tongue soreness?			Do you take nitroglycerin?		
			Do you get pain in your legs when you walk?		
THROAT:			Are your legs cold?		
Do you lose your voice?			Are you legs blue?		
Do you get frequent sore throats?			Coronary Vascular Disease risk factors:		
Do you have frequent tonsil infections?			Advanced Age		
Have you had your tonsils removed?			CVD Family History		
Has your voice changed?			Diabetes Mellitus		

CARDIOVASCULAR: (CONT.)	YES	NO	CARDIOVASCULAR: (CONT.)	YES	NO
Hyperlipidemia			Does your blood pressure drop standing?		
Cardio-Vascular Disease History/Factors			Have you had blood clots in your legs?		
Hypertension			Any Heart Rhythm Disturbance?		
Smoker			“Bradycardia”		
Obesity			“Cardiac Workup” needed & negative		
Sedentary Lifestyle			“PAC” History		
History Cardiac			“Palpitations”		
Abnormal EKG, Stress Test, ECHO			“PAT” History		
CABG			Present Treatment		
Congenital Disease			“PVC” History		
Aortic Valve Disease			“Rhythm Changes” History		
Atrial Septal Defect			“Tachycardia”		
Coarctation			Have you had blackout spells?		
Mitral Valve					
Pulmonic Valve			GASTROINTESTINAL (“GI”):		
Tetralogy of Fallout			Severe abdominal pain?		
Tricuspid Valve			Alcohol beverage consumption:		
Have you ever had a heart infection?			Describe drinks:		
Have you ever had a heart attack?					
History “Valvular” Diseases			Drinks/day/week:		
Aortic Insufficiency			Poor appetite history?		
Aortic Stenosis			History: Being more hungry than usual?		
Mitral Insufficiency			Bowel habit change? (diarrhea/constip)		
Mitral Prolapse			Do you have diarrhea?		
Mitral Stenosis			Do you have difficulty in swallowing?		
Pulmonic Insufficiency			Do you belch excessively?		
Pulmonic Stenosis			Pass gas excessively?		
Tricuspid Insufficiency			GI Disease History (details other side)		
Tricuspid Stenosis			Heartburn a problem?		
Do you have high blood fats?			Have you ever vomited blood?		
Do you have high blood pressure?			Hemorrhoids a problem?		
Told you have a heart murmur?			Ever had Jaundice (yellow skin/eyes)?		
Family History of:			Nausea a problem?		
Chorea?			Rectal pain a problem?		
Congestive Heart Failure (CHF)?			Bowel Movements (“stools”):		
Coronary Disease?			Color:		
Hyperlipidemia?			Consistency:		
Hypertension?			How often – average number:		
Myocardial Infarction			Gas (excessive)		
Peripheral Vascular Disease (PVD)			Odor		
Phlebitis			Abdominal Surgery? (details other side)		
Strokes			Recurrent Vomiting history?		
List Family Members:			Weight change history		
			Lbs. gained or lost in past year:		
			Over what period of time:		
			Other comments regarding GI System:		
Are you on heart medication?					
If yes, please list them:					

FEMALE GENITOURINARY:	YES	NO	PREGNANCIES:	YES	NO
Birth Control now or in the past (details on reverse side of page, please)			How many:		
Pain on intercourse?			Live births:		
Gynecological surgery? (details on reverse side of page)			Miscarriages:		
Ever had bloody urine?			Abortions:		
Lose urine involuntarily?			Pregnancy Complications (list if any):		
Constantly			Sexually transmitted disease history:		
Coughing/ sneezing			Genital Herpes		
Continuous urge to urinate			Chancroid, Syphilis, Gonorrhea?		
Pus in your urine?			Sex with one/multiple partners (circle)		
Pain on urination history					
Pelvic area significant pain			MALE GENITOURINARY:		
Kidney stone ever?			Any surgery on urinary tract?		
More than once?			Ever had bloody urine?		
Lithotripsy?			Involuntary urine loss?		
Had surgery or procedure?			Continuously?		
Vaginal discharge?			Under stress?		
Getting up to urinate at night?			With the sense of constant urging?		
1 time			Have colicky urinary pain?		
2 times			Kidney stone ever?		
3 times or more			More than once?		
Occasionally			Lithotripsy?		
Rarely			Had surgery or procedure?		
Urine Amount smaller than expected?			Getting up to urinate at night?		
Urine Amount larger than expected?			1 time		
Color of urine "abnormal"			2 times		
Urinate more often than expected?			3 times or more		
Difficulty emptying bladder?			Occasionally		
Burning on urination?			Rarely		
Painful to urinate?			Urine Amount smaller than expected?		
Cloudy urine?			Urine Amount larger than expected?		
Other:			Color of urine "abnormal"		
			Urinate more often than expected?		
			Constant urge to urinate?		
			Cloudy urine?		
MENSTRUAL HISTORY:			Trouble Emptying Bladder?		
Are you past menopause?			Able to have normal erections?		
Any menses after menopause?			HIV – AIDS?		
Date of last menses:			Discharge from penis ever?		
Was it abnormal or normal? (circle)			Sex with one partner?		
Age of your first period:			Sex with multiple partners?		
Are your periods regular?			Had venereal disease?		
Interval between periods (days):			Genital Herpes		
If in menopause:			Chancroid, Syphilis, Gonorrhea?		
Hot flashes?			Other history (please detail)		
Periods completely stopped?					
Were periods painful?			MUSCULO-SKELETAL:		
Your age when last period:			Joint Abnormalities:		
Unusual period history:			Arthritis? Which type:		
If heavy: tampons/day:					
Days of flow:			Joints affected:		
Other:					
			Stiffness:		
			If yes when:		
			Pain:		
			If yes: when, where & what causes:		

MUSCULO-SKELETAL (cont'd):	YES	NO	NEURO-PSYCHIATRIC:	YES	NO
Injury history (write > back of page)			Adjustment difficulties: (circle)		
			adolescence, family, illness, school		
Back Pain (describe on back of page)			workplace, sexual problems		
Neck Pain (describe on back of page)			Anxiety difficulties: (circle)		
Back surgery?			chronic?, pain attacks, worry?		
Orthopaedic Surgery? (back of page)			Depression:		
Restless Legs?			With anger or with mood swings?		
Awakened by joint pain			Loss of interest?		
Cannot walk more than a block			Sleep disturbance		
Muscle cramping anytime?			Eating or appetite loss problem		
			Self-destructive thoughts		
NEUROLOGICAL:			Hallucinations		
(CRANIAL NERVES):			Family history of: (circle)		
Any facial weakness?			Alcohol abuse, Anxiety, BiPolar		
Hearing Aids? Left/Right (Circle)			Dementia, Depression, Drugs		
Any deafness- history details on reverse			Panic Disorder, Personality Disorder		
Any facial numbness			Schizophrenia, Suicide		
Any loss of smell?					
Speech difficulties? Detail on reverse			ENDOCRINE:		
Visual problems? Detail on reverse side			Diabetes mellitus:		
(MOTOR):			Blurred vision, sugar in urine,		
Any muscles getting smaller?			Excessive thirst and or hunger		
History of epilepsy? Detail on reverse			Excessive urination		
Convulsions, seizures?			Unexplained weight loss		
Drug or alcohol history of note?			Hair loss		
Difficulty with balance?			Overweight since childhood		
Coordination problems?			Overweight since adulthood		
History of Stroke ("CVA")			Unusual skin pigmentation?		
Involuntary movements?			Secondary sexual characteristics		
Tremor?			Thyroid Disease?		
Parkinson's			Dry skin?		
			Prominent eyes?		
(SENSORY):			Goiter?		
Increased or loss of sensation?			"Hyperthyroid"?		
Paresthesiae (pins and needles)?			Intolerance to heat or cold?		
			Tremor		
(AUTONOMIC):			Thyroid medication		
"Raynaud's Disease"?			Weight change?		
Areas of blueishness/coldness?			Other "endocrine"?		
Face unusually pale?					
Abnormal reaction to heat or cold?			HEMATOLOGIC/LYMPHATIC:		
Unusual sweat pattern or reaction?			Anemia - diagnosed as having:		
			iron deficiency anemia		
(HEAD):			Abnormal "hemoglobin"		
History of "coma"			"Pernicious anemia"		
Dizziness problems?			"Thalassemia" abnormality		
Fall easily by losing balance?			"Sickle cell" abnormality		
Nausea associated with dizziness?			Factor deficiency (clotting, etc.)		
Room spinning around sensation?			Bleeding disorders (circle)		
Headaches ("HA")?:			Easy bleeding, familial bleeding		
Awaken with headache?			Petechiae, bruising		
"Cluster Headaches"?			Familial Histories		
Blind spots/visual changes?			Lymphatics:		
"Tension" headaches?			Hodgkin's/non-Hodgkins		
"Sinus" headaches history?			"CLL"		
Other headache history:			Any related diseases diagnosed?		
Head Trauma					

IMMUNOLOGY/ALLERGY:	YES	NO	Please add any uncovered items:		
List allergies:					
(use reverse side if necessary)					
Allergy treatment(?):					
Anti-histamine usage?					
Seasonally?					
Regularly?					
Desensitization treatment?					
Asthma history?					
If yes child, adult? (circle)					
Current medication					
Family history?					
Hay fever?					
Migraine Headaches?					
Runny nose?					
SKIN:					
Skin diseases?:					
Dermatitis?					
Eczema?					
Chronic Itching?					
Tuberculin skin test? Results?					
Chest x-ray result?					
Bleeding?					
Color change?					
Eruptions?					
Lesions?(describe on reverse page side)					
Pigmentation problems?					
Unusual pruritis (itching)?					
Scars? Where? (reverse side of page)					
Abnormal sweating					
HAIR:					
Male pattern baldness, color changes,					
Premature graying; thinning;					
Unusual distribution					
Hair loss, abnormal texture, extra hair,					
NAILS:					
Brittle?					
Off color?					
Fungus infected?					
Infections associated with nail bed?					
Ingrown?					
Pitting?					
Ridges?					
Psoriasis distorted?					