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Review of Systems



- Y A condition you have now
- N A condition you have NEVER had
- P A condition you have had in the past

1 GENERAL		Explanation (optional)		
Weight				
Weight 1 year ago				
Maximum weight				
When				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2 SKIN				
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/Moistness	Y	P	N	
Temperature	Y	P	N	
Nail changes	Y	P	N	
Change in mole	Y	P	N	
Skin cancer	Y	P	N	

3 HEAD				
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4 EYES				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

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5 EARS		Explanation (optional)			
	Impaired hearing	Y	P	N	
	Earache	Y	P	N	
	Dizziness	Y	P	N	
	Discharge	Y	P	N	
	Infections	Y	P	N	

6 NOSE and SINUSES					
	Frequent colds	Y	P	N	
	Nose bleeds	Y	P	N	
	Stuffiness	Y	P	N	
	Hay fever	Y	P	N	
	Sinus problems	Y	P	N	

7 MOUTH and THROAT					
	Frequent sore throat	Y	P	N	
	Sore tongue/mouth	Y	P	N	
	Gum problems	Y	P	N	
	Hoarseness	Y	P	N	
	Dental cavities	Y	P	N	
	Loss of taste	Y	P	N	

8 NECK					
	Lumps	Y	P	N	
	Swollen glands	Y	P	N	
	Goiter	Y	P	N	
	Pain or stiffness	Y	P	N	

9 RESPIRATORY					
	Cough	Y	P	N	
	Sputum	Y	P	N	
	Spitting up blood	Y	P	N	
	Wheezing	Y	P	N	
	Asthma	Y	P	N	
	Bronchitis	Y	P	N	
	Pneumonia	Y	P	N	
	Pleurisy	Y	P	N	
	Emphysema	Y	P	N	
	Difficulty breathing	Y	P	N	
	Pain on breathing	Y	P	N	
	Shortness of breath	Y	P	N	
	Shortness of breath at night	Y	P	N	
	Shortness of breath lying down	Y	P	N	
	Tuberculosis	Y	P	N	
	Tuberculin Test	Y	P	N	
	Last Chest X-ray	Y	P	N	

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10	CARDIOVASCULAR	Explanation (optional)			
	Heart disease	Y	P	N	
	Angina	Y	P	N	
	High blood pressure	Y	P	N	
	Murmurs	Y	P	N	
	Rheumatic fever	Y	P	N	
	Chest pain	Y	P	N	
	Swelling in ankles	Y	P	N	
	Palpitations, fluttering	Y	P	N	
	Cyanosis	Y	P	N	
	Past ECG	Y	P	N	
	Other heart tests	Y	P	N	

11	BREASTS	Explanation (optional)			
	Do you do self exam?	Y	P	N	
	Lumps?	Y	P	N	
	Pain (or tenderness)?	Y	P	N	
	Nipple Discharge?	Y	P	N	

12	GASTROINTESTINAL	Explanation (optional)			
	Trouble swallowing	Y	P	N	
	Heartburn	Y	P	N	
	Change in thirst	Y	P	N	
	Change in appetite	Y	P	N	
	Nausea	Y	P	N	
	Vomiting	Y	P	N	
	Vomiting blood	Y	P	N	
	Bowel movements - how often?	Y	P	N	
	Is this a change?	Y	P	N	
	Blood in stool?	Y	P	N	
	Belching or pressure gas?	Y	P	N	
	Jaundice (yellow skin)?	Y	P	N	
	Liver disease?	Y	P	N	
	Gall Bladder disease?	Y	P	N	
	Ulcer?	Y	P	N	
	Indigestion?	Y	P	N	
	Diarrhea?	Y	P	N	
	Rectal bleeding?	Y	P	N	
	Hemorrhoids?	Y	P	N	
	Black, tarry stool?	Y	P	N	
	Abdominal pain?	Y	P	N	
	Food allergies?	Y	P	N	
	Hernias?	Y	P	N	

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13 URINARY	Explanation (optional)			
Pain on urination?	Y	P	N	
Increased frequency?	Y	P	N	
Frequency at night?	Y	P	N	
Inability to hold urine?	Y	P	N	
Frequent infections?	Y	P	N	
Kidney stones?	Y	P	N	
Blood in urine?	Y	P	N	
Urgency?	Y	P	N	
Hesitancy?	Y	P	N	

14 MALE REPRODUCTIVE				
Hernias?	Y	P	N	
Testicular masses?	Y	P	N	
Testicular pain?	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties?	Y	P	N	
Venereal disease?	Y	P	N	
Discharge or sores?	Y	P	N	
Sexual preference: Heterosexual:	Y	P	N	
Bisexual:	Y	P	N	
Homosexual:	Y	P	N	

15 FEMALE REPRODUCTIVE				
Age menses began	Y	P	N	
Average number of days	Y	P	N	
Length of cycle	Y	P	N	
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
PMS	Y	P	N	
Birth control	Y	P	N	
What type?				
Number of pregnancies	Y	P	N	
Number of live births	Y	P	N	
Number of miscarriages	Y	P	N	
Number of abortions	Y	P	N	
Difficulty conceiving	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal diseases	Y	P	N	
Sexual preference: Heterosexual:	Y	P	N	
Bisexual:	Y	P	N	
Homosexual:	Y	P	N	

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Explanation (optional)

	Last menstrual period	Y	P	N	
	Vaginal discharge	Y	P	N	
	Vaginal itching	Y	P	N	
	Last PAP (date)	Y	P	N	

16	MUSCOLOSKELETAL				
	Joint pain or stiffness	Y	P	N	
	Arthritis	Y	P	N	
	Broken bones	Y	P	N	
	Muscle spasms or cramps	Y	P	N	
	Weakness	Y	P	N	
	Joint swelling	Y	P	N	
	Back ache	Y	P	N	

17	PERIPHERAL VASCULAR				
	Deep leg pain	Y	P	N	
	Cold hands/feet	Y	P	N	
	Varicose veins	Y	P	N	
	Thrombophlebitis	Y	P	N	
	Leg cramps	Y	P	N	
	Extremity numbness	Y	P	N	
	Extremity coldness	Y	P	N	
	Extremity swelling	Y	P	N	
	Extremity ulcers	Y	P	N	

18	NEUROLOGIC				
	Fainting	Y	P	N	
	Seizures/Convulsions	Y	P	N	
	Paralysis	Y	P	N	
	Muscle weakness	Y	P	N	
	Numbness or tingling	Y	P	N	
	Loss of memory	Y	P	N	
	Involuntary movement	Y	P	N	
	Loss of balance	Y	P	N	
	Speech problems	Y	P	N	

19	ENDOCHRINE				
	Heat or cold intolerance	Y	P	N	
	Thyroid trouble	Y	P	N	
	Excessive thirst	Y	P	N	
	Excessive hunger	Y	P	N	
	Excessive urination	Y	P	N	
	Excessive sweating	Y	P	N	
	Diabetes	Y	P	N	
	Hypoclycemia	Y	P	N	
	Hormone Therapy	Y	P	N	

