Review of Systems

Please answer all the questions on both sides of the page

Name: ______________________________ Date: ____________ Birth date_______________

Allergies: (food, medication, other):____

Why are you being seen in the office today? ______________________________________

____

Have you experienced any of the following recently or since your last visit?

Symptom	Y	N	Symptom	Y	N
Weight loss / or gain	Y	N	Bowel problems	Y	N
Fatigue	Y	N	Painful periods	Y	N
Fever / Chills	Y	N	Breast pain/Lump/Nipple Discharge	Y	N
Vision changes	Y	N	Hot flashes	Y	N
Dental problems	Y	N	Sore throat	Y	N
Dizziness	Y	N	Vomiting Blood	Y	N
Sinus problems	Y	N	Headaches	Y	N
SOB/ Wheezing /Blood Tinged Mucus	Y	N	Numbness/Tingling in hands/ feet	Y	N
Muscle weakness/ pain	Y	N	Chest pain/palpitations/Rapid Heart Beats	Y	N
Swelling	Y	N	Joint pain / weakness	Y	N
Problems urinating	Y	N	Skin changes/ dry skin/ rash	Y	N
Nausea/vomiting/constipation/diarrhea	Y	N	Skin pain/ tenderness or itch	Y	N
Heart Burn	Y	N	Rectal Bleeding/ change in bowel movements	Y	N
Excessive thirst	Y	N	Excessive appetite	Y	N
Cough that won't go away	Y	N	Visual floaters, spots or disturbances	Y	N
Intolerance to heat or cold	Y	N	Bruising, bleeding problems	Y	N
Bleeding after intercourse	Y	N	Vaginal discharge	Y	N
Vaginal itching or dryness	Y	N	Pelvic pain	Y	N
Urinary frequency	Y	N	Blood in urine	Y	N
Up more than once per night to urinate	Y	N	Unable to control bladder	Y	N
Cuts that do not stop bleeding	Y	N			

Symptom	Y	N
Nasal congestion/ nose bleeds/ earache/ hearing problems/ nasal allergies	Y	N
Depression/suicidal thoughts/ unable to sleep/ memory loss/ mood swings/hallucinations	Y	N

Additional concerns or questions: ____

____

Please list all herbs, vitamins, and supplements you are taking: ____________________

____

Please list all over-the-counter medicines you are taking (Tylenol, Motrin, aspirin, etc.):

____

Please turn over

Patient Name:____

Please list all prescription medicines you are taking: _______________________________

____

Have there been any changes in your or your families' medical history since your last visit?

____

____

List any surgeries you have had/when: (If you are an existing patient, only list any surgeries since your last visit):

____

____

Did you or have you ever used/ taken:

Alcohol	N	Y-- Amount per day/ week________
Tobacco	N	Y-- Amount per day/ week________
Medications not prescribed to you	N	Y-- What? ____________________
Street Drugs (Cocaine, Marijuana, etc.)	N	Y—What? ___________________

If you are new to this practice, how did you hear about us? _____________________________

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