

REVIEW OF SYSTEMS – Updated

PATIENT NAME: _____ **DOB:** _____

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

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Other _____

Eyes

Blurred vision Y N
 Double vision Y N
 Pain Y N
 Other _____

Allergic/Immunologic

Hay Fever Y N
 Drug allergies Y N
 Other _____

Neurological

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

Endocrine

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

Gastrointestinal

Abdominal pain Y N
 Indigestion/heartburn Y N
 Other _____

Cardiovascular

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

Integumentary

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

Musculoskeletal

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

Ear/Nose/Throat/Mouth

Ear infection Y N
 Sore throat Y N
 Sinus problems Y N
 Other _____

Genitourinary

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

Respiratory

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

Hematologic/ Lymphatic

Swollen glands Y N
 Blood clotting problem 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 _____

Physician use only: (Comments/Notes)

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

Physician: _____

Date: ___/___/___