Review of Systems

Do you now or have you had any problems related to the following systems? CIRCLE YES OR NO

Please explain any Yes answers in the 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
- Hey 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
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Intgumentary
- 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 frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychological
- Are you generally satisfied with your life Y N
- Do you feel severely depressed Y N
- Have you ever 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**_____/_____/_____