Review of Systems

Name:

Date:

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

				Responses and Comments:
GENERAL				
Weight				
Weight one year ago				
Maximum weight				When?
Minimum weight				When?
Height				
Fatigue/weakness	**Y**	**P**	**N**	
Fever/chills	**Y**	**P**	**N**	
SKIN				
Rashes	**Y**	**P**	**N**	
Eczema, hives	**Y**	**P**	**N**	
Acne, boils	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Colour change	**Y**	**P**	**N**	
Lumps	**Y**	**P**	**N**	
Night sweats	**Y**	**P**	**N**	
Dryness/moistness	**Y**	**P**	**N**	
Nail changes	**Y**	**P**	**N**	
Change in mole	**Y**	**P**	**N**	
Skin cancer	**Y**	**P**	**N**	
HEAD				
Headache	**Y**	**P**	**N**	
Head injury	**Y**	**P**	**N**	
Dizziness	**Y**	**P**	**N**	
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**	
EARS				
Impaired hearing	**Y**	**P**	**N**	
Earache	**Y**	**P**	**N**	
Dizziness	**Y**	**P**	**N**	
Discharge	**Y**	**P**	**N**	
Infections	**Y**	**P**	**N**	
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**	
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**	
NECK				
Lumps	**Y**	**P**	**N**	
Swollen glands	**Y**	**P**	**N**	
Goiter (enlarged thyroid)	**Y**	**P**	**N**	
Pain or stiffness	**Y**	**P**	**N**	
RESPIRATORY				
Cough	**Y**	**P**	**N**	
Sputum/Phlegm	**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				
CARDIOVASCULAR				
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 (ex. lips or skin turn blue)	**Y**	**P**	**N**	
Past ECG	**Y**	**P**	**N**	
Other heart tests	**Y**	**P**	**N**	
BREASTS				
Do you do self exams?	**Y**	**P**	**N**	
Lumps	**Y**	**P**	**N**	
Pain (or tenderness)	**Y**	**P**	**N**	
Nipple discharge	**Y**	**P**	**N**	
GASTROINTESTINAL				
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?				
Is this a change?	**Y**	**P**	**N**	
Blood in stool	**Y**	**P**	**N**	

Belching or passing 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**	
Constipation	**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 allergy	**Y**	**P**	**N**	
Hernias	**Y**	**P**	**N**	
URINARY				
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**	
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 orientation: Heterosexual	**Y**	**P**	**N**	
Bisexual	**Y**	**P**	**N**	
Homosexual	**Y**	**P**	**N**	
Other	**Y**	**P**	**N**	

FEMALE REPRODUCTIVE				
Age menses began				
Average number of days				
Length of cycle				
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				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	**Y**	**P**	**N**	
Are you sexually active?	**Y**	**P**	**N**	
Sexual difficulties	**Y**	**P**	**N**	
Venereal disease	**Y**	**P**	**N**	
Sexual orientation: Heterosexual	**Y**	**P**	**N**	
Bisexual	**Y**	**P**	**N**	
Homosexual	**Y**	**P**	**N**	
Other	**Y**	**P**	**N**	
Last menstrual period				
Vaginal discharge	**Y**	**P**	**N**	
Vaginal itching	**Y**	**P**	**N**	
Last PAP – (date)				
MUSCULOSKELETAL				
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**	
Backache	**Y**	**P**	**N**	

PERIPHERAL VASCULAR				
Deep leg pain	**Y**	**P**	**N**	
Cold hands/feet	**Y**	**P**	**N**	
Varicose veins	**Y**	**P**	**N**	
Thrombophlebitis (clotting disorder)	**Y**	**P**	**N**	
Leg cramps	**Y**	**P**	**N**	
Extremity numbness	**Y**	**P**	**N**	
Extremity coldness	**Y**	**P**	**N**	
Extremity ulcers	**Y**	**P**	**N**	
Extremity swelling	**Y**	**P**	**N**	
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**	
ENDOCRINE				
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**	
Diabetes	**Y**	**P**	**N**	
Hypoglycemia	**Y**	**P**	**N**	
Hormone therapy	**Y**	**P**	**N**	
BLOOD/LYMPHATIC				
Anemia	**Y**	**P**	**N**	
Easy bleeding or bruising	**Y**	**P**	**N**	
Past transfusions	**Y**	**P**	**N**	
Lymph node swelling	**Y**	**P**	**N**	
ALLERGIC HISTORY				
Drug sensitivity	**Y**	**P**	**N**	
Reaction to vaccine	**Y**	**P**	**N**	
Allergies? Please list.	**Y**	**P**	**N**	

EMOTIONAL				
Depression	**Y**	**P**	**N**	
Mood swings	**Y**	**P**	**N**	
Anxiety or nervousness	**Y**	**P**	**N**	
Tension	**Y**	**P**	**N**	
Phobias	**Y**	**P**	**N**	
Alcohol/drug abuse	**Y**	**P**	**N**	
Insomnia	**Y**	**P**	**N**	
HOBBIES/HABITS				
Do you eat three meals daily?	**Y**	**P**	**N**	
Do you awake rested?	**Y**	**P**	**N**	
Do you sleep well?	**Y**	**P**	**N**	
Do you average 6-8 hours sleep?	**Y**	**P**	**N**	
Do you enjoy your work?	**Y**	**P**	**N**	
Do you watch television?	**Y**	**P**	**N**	
How many hours/day?				
How many hours per day do you spend in front of a computer?				
Do you read?	**Y**	**P**	**N**	
Do you exercise?	**Y**	**P**	**N**	
What forms?				
How many times a week?				
Do you take vacations?	**Y**	**P**	**N**	
Have you been treated for drug dependence?	**Y**	**P**	**N**	
Do you use recreational drugs?	**Y**	**P**	**N**	
Do you consume alcoholic beverages?	**Y**	**P**	**N**	
Have you been treated for alcoholism?	**Y**	**P**	**N**	
How often?				
What are your main interests and hobbies?	**Y**	**P**	**N**	