

Name _____

Date _____

REVIEW OF SYSTEMS

Please check any symptoms you have experienced in the past.

HEENT:

- Dizziness or vertigo yes no
- Headaches yes no
- Visual Problems yes no
- Wear glasses yes no
- Problem with ears yes no
- Hay fever / sinus problems yes no
- Fainting spells yes no
- Thyroid disease yes no

PULMONARY:

- Cough yes no
- Coughing up blood yes no
- Shortness of breath on walking yes no
- Night sweats yes no
- Asthma yes no
- Pneumonia yes no
- Tuberculosis yes no

CARDIAC:

- Chest pain or angina yes no
- History of "heart trouble" yes no
- Wake up at night short of breath yes no
- Sleep on more than one pillow yes no
- Palpitations or fluttering of heart yes no
- High blood pressure yes no
- Swelling of hands, feet or ankles yes no
- "Black out" spells yes no
- Heart murmurs yes no
- Shortness of breath with exertion yes no

GASTROINTESTINAL:

- Appetite good fair poor
- Nausea or Vomiting yes no
- Indigestion or heartburn yes no
- Intolerance of certain foods yes no
- Recent weight loss or gain yes no
- Diarrhea yes no
- Constipation yes no
- Hemorrhoids yes no
- Blood in bowel movement yes no
- Black or tarry stools yes no

GENITO-URINARY:

- Pain on urinating yes no
- Difficulty in starting urine yes no
- Do you get up in the night to urinate yes no
How many times: _____
- Any blood in urine yes no
- Lose urine on coughing or sneezing yes no
- Hernia yes no
- History of Kidney Stones yes no

EXTREMITIES:

- Joint pains or stiffness yes no
- Swelling of any joints yes no
- Tingling, weakness or numbness of hands or feet yes no
- Leg cramps with walking yes no
- Enlarged veins in legs yes no

NEUROPSYCHIATRIC:

- Difficulty in sleeping yes no
- Nervous disorder yes no
- Seizure disorder yes no

BREAST:

- Swelling or pain yes no
- Discharge from nipple yes no
- History of breast cancer in family yes no
- Breast nodules yes no

HEMATOLOGICAL:

- Excessive bleeding followin cuts yes no
Or dental work yes no
- Easy bruising yes no

PREGNANCIES:

- How many children born alive _____
- How many still births _____
- How many miscarriages _____
- How many cesarean sections _____
- Any complications with pregnancy _____
- Describe: _____
- _____
- _____
- _____

Patient Signature Date