Review of Systems

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

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Weight gain/loss	Y	N

Other _____

Eyes

Double Vision	Y	N
Pain	Y	N
Blurred Vision	Y	N

Other _____

Ear/Nose/Throat/Mouth

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

Other _____

Respiratory

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

Other _____

Gastrointestinal

Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N
Abdominal Pain	Y	N

Other _____

Genitourinary

Urinary frequency	Y	N
Painful urination	Y	N
Urine retention	Y	N

Other _____

Musculoskeletal

Back pain	Y	N
Neck pain	Y	N
Joint pain	Y	N

Other _____

Integumentary

Boils	Y	N
Persistent itching	Y	N
Skin rash	Y	N

Other _____

Neurological

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

Other _____

Endocrine

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

Other _____

Hematologic/Lymphatic

Blood clotting problem	Y	N
Swollen glands	Y	N

Other _____

Allergic/Immunologic

Drug allergies	Y	N
Hay Fever	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 _____

If yes to any answer, give brief explanation:

_____

_____

_____

_____

Provider use only: (Comments/Notes)

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

Provider: _____ Review Date: _____

Provider: _____ Review Date: _____

Provider: _____ Review Date: _____