REVIEW OF SYSTEMS

Name____Date________________

FOR THE FOLLOWING, PLEASE CIRCLE
Y = a condition you have now P = a condition you had in the past N = a condition you never had

IMMUNE

Unexplained fever? Y P N
Chronically swollen glands? Y P N
Chronic infections? Y P N
Fungal infection? Y P N
If yes, where? ______________________
Chronic Fatigue Syndrome? Y P N
Slow wound healing? Y P N

ENDOCRINE

Fatigue? Y P N
Seasonal depression? Y P N
Hyperthyroid? Y P N
Hypothyroid? Y P N
Diabetes? Y P N
Hypoglycemia? Y P N
Excessive thirst? Y P N
Thirstlessness? Y P N
Excessive hunger? Y P N
Lack of appetite? Y P N
Heat intolerance? Y P N
Cold intolerance? Y P N
Heat & cold flashes? Y P N

NEUROLOGIC

Loss of memory? Y P N
Loss of balance? Y P N
Clumsiness? Y P N
Numbness or tingling? Y P N
Trembling hands? Y P N
Carpal tunnel syndrome? Y P N
Seizures? Y P N
Paralysis? Y P N

EMOTIONAL

Anxiety or nervousness? Y P N
Tension? Y P N
Insomnia? Y P N
Depression? Y P N
Hopelessness? Y P N
Mood Swings? Y P N
Recent loss of loved one? Y P N
Considered/Attempted suicide? Y P N

CARDIOVASCULAR

High Blood Pressure? Y P N
Low Blood Pressure? Y P N
Swelling in ankles? Y P N
Fainting? Y P N
Dizziness upon rising? Y P N
Chest pain? Y P N
Angina? Y P N
Heart disease? Y P N
Murmurs? Y P N
Palpitations/Fluttering? Y P N
Blood clots? Y P N
Phlebitis? Y P N
Rheumatic Fever? Y P N
Pace maker? Y N
Electrocardiogram? Y N
Electroencephalogram? Y N

BLOOD/PERIPHERAL VASCULAR

Cold hands/feet? Y P N
Deep leg pain? Y P N
Easy bleeding or bruising? Y P N
Difficulty stopping bleeding? Y P N
Slow wound healing? Y P N
Anemia? Y P N
Varicose veins? Y P N
Thrombophlebitis? Y P N
Date of last blood test __________________

URINARY

Pain on urination? Y P N
Difficulty urinating? Y P N
Increased frequency? Y P N
Frequency at night? Y P N
Unexplained urgency to urinate? Y P N
Inability to hold urine? Y P N
Frequent infections? Y P N
Blood in urine? Y P N
Kidney stones? Y P N

Anything else_________________________

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HEAD

Headaches?	Y P N
Migraines?	Y P N
Head Injury?	Y P N
Jaw/TMJ problems?	Y P N

EYES

Glasses or contacts?	Y P N
Loss of central vision?	Y P N
Loss of Peripheral vision?	Y P N
Blurriness?	Y P N
Spots in Eyes?	Y P N
Eye pain/strain?	Y P N
Tearing or dryness?	Y P N
Red?	Y P N
Cataracts?	Y P N
Double Vision?	Y P N
Exopthalomos?	Y P N
Glaucoma?	Y P N
Color blindness?	Y P N

EARS

Earaches?	Y P N
Discharge from ears?	Y P N
Sensitivity to noise?	Y P N
Ringing in ears?	Y P N
Vertigo or dizziness?	Y P N
Hearing Impaired?	Y P N
Hearing Aid?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N
Sinus problems?	Y P N
Stuffiness?	Y P N
Hayfever?	Y P N
Loss of smell?	Y P N
Nose Bleeds?	Y P N

NECK

Lumps?	Y P N
Goiter?	Y P N
Pain or stiffness?	Y P N

MOUTH AND THROAT

Sore lips?	Y P N
Cold sores or blisters?	Y P N
Dry mouth?	Y P N
Copious saliva?	Y P N
Sore tongue?	Y P N
Sore gums?	Y P N
Bleeding gums?	Y P N
Dental cavities?	Y P N
Teeth grinding?	Y P N
Teeth sensitive to hot or cold?	Y P N
Dentures?	Y P N
Frequent sore throat?	Y P N
Swollen glands?	Y P N
Difficulty swallowing?	Y P N
Hoarseness?	Y P N
Speech problems?	Y P N

How often you brush your teeth? ________

RESPIRATORY

Cough?	Y P N
Sputum?	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
Tuberculosis?	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

How many pillow do you use to sleep? _____

Anything else________________________

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GASTROINTESTINAL

Bad breath?	Y P N
Bad taste in mouth?	Y P N
Heartburn?	Y P N
Nausea?	Y P N
Vomiting?	Y P N
Vomiting with blood?	Y P N
Abdominal bloating?	Y P N
Belching or passing gas?	Y P N
Pain or cramps?	Y P N
How many Bowel Movements /day ________	
Is this a change?	Y P N
Constipation	Y P N
Diarrhea?	Y P N
Color of stools? ______________________	
Food in stools?	Y P N
Blood in stools?	Y P N
Mucus in stools?	Y P N
Hemorrhoids?	Y P N
Rectal bleeding?	Y P N
Rectal Itching?	Y P N
Liver Disease?	Y P N
Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N
Ulcer?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N
Arthritis?	Y P N
Broken bones?	Y P N
Bone replacements	
Muscle weakness?	Y P N
Muscle spasms or cramps?	Y P N
Muscle tremor?	
Trouble writing?	Y P N
Trouble opening jars?	Y P N
Neck or shoulder pain?	Y P N
Back pain?	Y P N
Leg pains?	Y P N
Sciatica?	Y P N
Bunions?	Y P N

SKIN

Pain?	Y P N
Dry?	Y P N
Rough?	Y P N
Cracking?	Y P N
Itching?	Y P N
Scaling?	Y P N
Burning?	Y P N
Bruising?	Y P N
Rashes?	Y P N
Hives?	Y P N
Corns?	Y P N
Calyces?	Y P N
Fungus?	Y P N
Lumps?	Y P N
Color Change?	Y P N
Pressure ulcers?	Y P N
Perpetual Hair Loss?	Y P N
Acne?	Y P N
Boils?	Y P N
Cysts?	Y P N
Eczema?	Y P N
Psoriasis?	Y P N
Scars?	Y P N
Warts?	Y P N
Moles?	Y P N
Any change in size or color?	Y P N
Nails brittle/ misshapen?	Y P N
White spots in nails?	Y P N
Bite nails?	Y P N
Fungal infection under nails?	Y P N
Other? ______________________________	

Anything else_________________________

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PITTUITATY

Failing memory? Y P N
Low blood pressure? Y P N
Increase sex desire? Y P N
Splitting headaches? Y P N
Menstrual disorders? Y P N
High/Low sugar intolerance? Y P N
Intestinal bloating? Y P N
Abnormal thirst? Y P N
Decreased sex desire? Y P N
Chunky hips or waist? Y P N
Ulcers, colitis? Y P N

THYROID

Overweight? Y P N
Underweight? Y P N
Decrease appetite? Y P N
Increased appetite? Y P N
Difficulty losing weight? Y P N
Constipation? Y P N
Tired upon rising? Y P N
Easily fatigued? Y P N
Dry or scaly skin? Y P N
Nervousness? Y P N
Irritable/restless? Y P N
Heart palpitations? Y P N
Chilly/sensitive to cold? Y P N
Flush/get hot easily? Y P N
Insomnia? Y P N
Mental slowness ? Y P N
Date of last Thyroid blood test__________

Sympathetic Nervous System

Upset from acid foods? Y P N
Dry eyes, nose, mouth? Y P N
Nervousness? Y P N
Wound heal slowly? Y P N
Gag easily? Y P N
Very quick mentally? Y P N
Cold extremities? Y P N
Light sensitive? Y P N
Decreased urine output? Y P N
Heart pounds when lying? Y P N
Reduced appetite? Y P N
Frequent cold sweats? Y P N

ADRENALS

Easily stressed? Y P N
Easily/chronically fatigue? Y P N
Dizziness? Y P N
Headaches? Y P N
Hot flashes? Y P N
Bronzing of the skin? Y P N
Craves salt? Y P N
Nails week, ridged? Y P N
Tendency to get hives? Y P N
Rheumatism/arthritis? Y P N
Poor circulation
Increased blood pressure? Y P N
Weak after getting a cold? Y P N
Facial hair (women)? Y P N

Parasympathetic Nervous System

Joint stiffness on rising? Y P N
Muscle/leg/toe cramps? Y P N
Butterfly stomach cramps? Y P N
Digestion rapid? Y P N
Indigestion after eating? Y P N
Frequent vomiting? Y P N
Alternating constipation/diarrhea? Y P N
Perspiration scant/absent? Y P N
Perspire easily/profusely? Y P N
Pulse slow/irregular? Y P N
Breathing irregular? Y P N
Poor circulation? Y P N
Eyelids swollen/puffy? Y P N

Central & Peripheral Nervous System

Loss of balance/fainting? Y P N
Dizziness regularly? Y P N
Convulsions (seizures)? Y P N
Tremor (shaking, trembling)? Y P N
Blurred/double vision? Y P N
Is one arm or leg shorter than the other? Y N
Paralysis? Y P N
Numbness/tingling (circle)? Y P N
Temporary loss of sensation? Y P N
Lack of strength? Y P N
Continual headaches? Y P N

Anything else_________________________

REPRODUCTION

Are you sexually active? Y N

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Heterosexual? Y P N
Homosexual? Y P N
Bisexual? Y P N
Birth control? Type? _______________ Y N
Venereal disease? Y P N
Gonorrhea? Y P N
Chlamydia? Y P N
Condyloma? Y P N
Herpes? Y P N
Syphilis? Y P N
Discharge? Y P N
Sores? Y P N
Pain during intercourse? Y P N
Sexual difficulties? Y P N

MALE REPRODUCTION

Hernias? Y P N
Testicular pain? Y P N
Testicular masses? Y P N
Prostate disease? Y P N
Impotence? Y P N
Premature ejaculation? Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? ____________________
Number of pregnancies _________________
Number of live births __________________
Number of miscarriages ________________
Number of abortions ___________________
Difficulty conceiving? Y P N
Are you currently menstruating? Y N
Are cycles regular? Y N
Length of cycle? ______________ days
Duration of menses? ___________ days
Bleeding between cycles? Y P N
Painful menses? Y P N
Clotting? Y P N
Heavy or excessive flow? Y P N
PMS? Y P N
If yes, what are your symptoms?
____
____
Pelvic pain? Y P N
Cervical Dysplasia? Y P N
Endometriosis? Y P N
Ovarian cysts? Y P N
Menopausal symptoms? Y P N
Abnormal PAP? Y P N
Date last pap? __________________
Date last mammogram?____________
Do you do breast self exams? Y P N
How often ________________________
Breast lumps? Y P N
Breast pain/tenderness? Y P N
Nipple discharge? Y P N

Anything else_________________________

REVIEW OF SYSTEMS

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MENTAL STATUS

Anxiety?	Y P N
Restlessness?	Y P N
Excessive worry?	Y P N
Shy, timid?	Y P N
Lack self-confidence?	Y P N
Critical of self?	Y P N
Critical of others?	Y P N
Prefer to be w/ company?	Y P N
Would rather be alone?	Y P N
Afraid when left alone?	Y P N
Feel alone/Lonely?	Y P N
Don't seek out company?	Y P N
Prefer to be left alone when not feeling well?	Y P N
Affectionate?	Y P N
Like affection?	Y P N
Intimate with others?	Y P N
Memory difficulties, forgetful?	Y P N
Mental confusion?	Y P N
Decreased comprehension?	Y P N
Decreased concentration?	Y P N
Make many mistakes?	Y P N
Depression?	Y P N
Despair/Discontent?	Y P N
Suicidal thoughts?	Y P N
Mood swings?	Y P N
Suspicious/jealous?	Y P N
Sensitive to noises?	Y P N
Any known physical abuse	Y P N
Any known sexual abuse	Y P N
Any known mental abuse	Y P N
Is sex life satisfactory	Y P N
Assertive, powerful?	Y P N
Confident, secure?	Y P N
Organized, neat/clean?	Y P N

Anger:

Do you get angry often/easily?	Y P N
Do you experience uncontrollable rage?	Y P N
Do you have difficulty expressing anger?	Y P N

How do you express anger? ____________________

What makes you anger? ________________________

____

Sadness:

Do you cry when sad?	Y P N
Do you cry easily/often?	Y P N
Would you rather be left alone when sad?	Y P N
Does being consoled help?	Y P N

What makes you sad? ________________________

____

Grief:

List major experiences of grief/loss in your life.

Fears:

Do you have any fears?	Y P N
Are any unmanageable?	Y P N

What fears do you have?

Are you happy/content with your life presently? Y P N

Why or why not? ______________________________

How does your present condition affect you? __________

____

What do you enjoy most in your life?

____

____

What do you feel needs to happen for you to get better? ____

____

____

THANK YOU FOR YOUR COOPERATION, PATIENCE AND THOROUGHNESS.