

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 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

Hay 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 _____

Integumentary

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
Other _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem 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 _____

Physician use only: (Comments/Notes)

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

Physician: _____

Date: ____/____/____