

# PATIENT REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark the box with a "C" if your symptom is **CURRENT** and with an "H" if it is in your past **HISTORY**.

GENERAL		LUNGS		PSYCHOLOGIC		MEDICAL		MEDICATIONS / VITAMINS	
Fever	<input type="checkbox"/>	Breathing Difficulty	<input type="checkbox"/>	Excessive Stress	<input type="checkbox"/>	<b>Surgery - any area (LIST)</b>		<b>Prescription Medications ***</b>	
Sweats	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	Non-prescribed medication ***	
Chills	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	Drug Allergies	
Weight Loss/Gain	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<b>SKIN</b>		Substance Abuse	<input type="checkbox"/>	Allergies	
Sleep Disturbance	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Rash / Itching	<input type="checkbox"/>	Last Laboratory Test	<input type="checkbox"/>	Recreational Drugs	
HEAD		Pneumonia		Bruising	<input type="checkbox"/>	Last Chest x-ray	<input type="checkbox"/>	Vitamins ***	
Headache	<input type="checkbox"/>	<b>VASCULAR</b>		Hair Loss	<input type="checkbox"/>	<b>SOCIAL</b>		*** Bring a list (LIST BELOW)	
Dizziness	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Changes in Moles	<input type="checkbox"/>	Consume Alcohol	<input type="checkbox"/>	<b>LISTS</b>	
Head Trauma	<input type="checkbox"/>	Palpatations	<input type="checkbox"/>	Peeling	<input type="checkbox"/>	Consume Coffee	<input type="checkbox"/>	<b>SURGERIES</b>	
Fainting / Black Out	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<b>NEUROLOGIC</b>		Consume Tea	<input type="checkbox"/>	<b>YEAR</b>	
EYES		Cold/Hot Feet / Hands	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	Consume Sodas	<input type="checkbox"/>		
Vision	<input type="checkbox"/>	Discolored Foot/Hand	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	Smoker	<input type="checkbox"/>		
Blurry	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	Tingling / Numbness	<input type="checkbox"/>	Aerobic Exercise	<input type="checkbox"/>		
Double	<input type="checkbox"/>	Calf Pain	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Water Intake/ Day	<input type="checkbox"/>		
Flashes	<input type="checkbox"/>	Vericose Veins	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	Herbs	<input type="checkbox"/>		
Spots	<input type="checkbox"/>	Low / High Blood Pressure	<input type="checkbox"/>	Poor Coordination	<input type="checkbox"/>	Hobbies	<input type="checkbox"/>		
Contacts / Glasses	<input type="checkbox"/>	<b>G-I SYSTEM</b>		<b>MUSCLE / BONE</b>		<b>OB GYN - FOR FEMALES</b>			
Cataracts	<input type="checkbox"/>	Gas	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Last Breast Exam	<input type="checkbox"/>		
Sensitive to Light	<input type="checkbox"/>	Heartburn / Indigestion	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	Last PAP date	<input type="checkbox"/>		
<b>EARS</b>		Ulcers	<input type="checkbox"/>	Muscle Ache	<input type="checkbox"/>	Pregnancy(s) - past	<input type="checkbox"/>		
Ringing	<input type="checkbox"/>	Vomiting / Nausea	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Pregnancy-current	<input type="checkbox"/>	<b>MEDICATIONS</b>	
Infections	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Deformity	<input type="checkbox"/>	Mastectomy	<input type="checkbox"/>	<b>DOSE</b>	
Hearing Loss	<input type="checkbox"/>	Diahrea / Constipation	<input type="checkbox"/>	Bone Pain	<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>		
Drainage	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Nipple Discharge	<input type="checkbox"/>		
Pain	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<b>Dislocations (LIST)</b>		Hysterectomy	<input type="checkbox"/>		
NOSE		Gall Bladder Disease	<input type="checkbox"/>	<b>CONDITIONS</b>		PMS	<input type="checkbox"/>		
Nosebleeds	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>		
Sinus Problems	<input type="checkbox"/>	<b>G-U SYSTEM</b>		Diabetes	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>		
MOUTH		Urine	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>		
Bleeding Gums	<input type="checkbox"/>	Difficulty Going	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<b>FAMILY HISTORY</b>			
Jaw Pain	<input type="checkbox"/>	Pain w/ urinating	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<b>WHOM?</b>			
Swelling	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<b>BROKEN BONES / DISLOCATIONS</b>	
Dental Problems	<input type="checkbox"/>	Foul Odor	<input type="checkbox"/>	Cancer / Tumor	<input type="checkbox"/>	Colorectal Cancer	<input type="checkbox"/>	<b>BODY PART</b>	
Dentures	<input type="checkbox"/>	Increased	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<b>YEAR</b>	
NECK		Decreased	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>		
Masses	<input type="checkbox"/>	Infection	<input type="checkbox"/>	Multiple Schlerosis	<input type="checkbox"/>	Depression	<input type="checkbox"/>		
Swelling	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Epilspy	<input type="checkbox"/>		
Stiffness	<input type="checkbox"/>	Genital Infection	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>		