Review of Systems

Do you now, or have you had, any problems related to the following systems? Circle Yes (Y) or No (N)

Please explain any Yes (Y) answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other_____	Y	N

Allergic / Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other_____	Y	N

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other_____	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other_____	Y	N

Gastrointestinal

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

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other_____	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other_____	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other_____	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other_____	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other_____	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other_____	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
Other_____	Y	N

Pyschologic

Are you generally satisfied with life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other_____	Y	N

Physician Use Only: (Comments/Notes)

# Answers	Level of Service
0 or 1	1 or 2
2 thru 9	3
10 +	4 or 5

Physician _____ Date _____