NAME ____ DOB________________________________

REVIEW OF SYSTEMS

Do you now or have you ever had any chronic problems related to the following systems? Circle **YES** or **NO**. Please explain any **YES** answers in the space provided. Thank you.

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 Problems	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)

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

Physician: ____ Date:______________________