

REVIEW OF SYSTEMS – ADULT

Please take a moment to complete the following. *In the last 3 months* have you experienced any of the following?

Please indicate **Yes** or **No** and **explain** if appropriate.

GENERAL		Yes	No	Please explain further.
		<input type="checkbox"/>	<input type="checkbox"/>	Do you have allergies to medications? If so, please list them and the reaction they caused.
		<input type="checkbox"/>	<input type="checkbox"/>	Recurrent fever or chills?
		<input type="checkbox"/>	<input type="checkbox"/>	Unintentional weight loss?
		<input type="checkbox"/>	<input type="checkbox"/>	Recurrent fatigue or malaise?
SKIN		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Rash or skin color changes?
		<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellowing of the skin or eyes)?
		<input type="checkbox"/>	<input type="checkbox"/>	Moles that are changing color or size?
HEENT		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Headaches that are new or changing in frequency or severity?
		<input type="checkbox"/>	<input type="checkbox"/>	Hearing changes?
		<input type="checkbox"/>	<input type="checkbox"/>	Visual changes? (If yes, are you seeing an eye doctor?)
		<input type="checkbox"/>	<input type="checkbox"/>	Non-healing mouth sores?
		<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands or neck lumps?
		<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness?
RESPIRATORY		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Cough that is chronic, produces phlegm or is changing?
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing?
		<input type="checkbox"/>	<input type="checkbox"/>	Wheezing?
		<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or are you exposed to 2 nd hand smoke?
CARDIAC		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure?
		<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with normal activity?
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing when lying flat?
		<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath that wakes you from sleep?
		<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (sensation of heart beating in your chest)?
		<input type="checkbox"/>	<input type="checkbox"/>	Swelling in the ankles?
GASTROINTESTINAL		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Difficult or painful swallowing?
		<input type="checkbox"/>	<input type="checkbox"/>	Recurrent nausea or vomiting?
		<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea or constipation?
		<input type="checkbox"/>	<input type="checkbox"/>	Recurrent abdominal pain or cramping?
		<input type="checkbox"/>	<input type="checkbox"/>	Bloody or black bowel movements?
GENITOURINARY		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination?
		<input type="checkbox"/>	<input type="checkbox"/>	Dark or reddish urine?
		<input type="checkbox"/>	<input type="checkbox"/>	Involuntary loss of urine?
		<input type="checkbox"/>	<input type="checkbox"/>	Decreased force of urine stream or difficulty starting urine?
		<input type="checkbox"/>	<input type="checkbox"/>	Problems achieving or maintaining erections?
MUSCULOSKELETAL		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	Painful joints? (If yes, which ones?)
		<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints?
		<input type="checkbox"/>	<input type="checkbox"/>	Morning joint stiffness? (If yes, how long does the stiffness last?)

***** **TURN OVER AND COMPLETE OTHER SIDE** *****

NAME: _____

DATE: _____

PROVIDER REVIEW: _____

In the last 3 months have you experienced any of the following? Please indicate **Yes** or **No** and **explain** if appropriate.

NEUROLOGIC		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent dizziness?
<input type="checkbox"/>	<input type="checkbox"/>	Fainting?
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs?
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling in arms or legs?
<input type="checkbox"/>	<input type="checkbox"/>	Un-coordination or loss of balance?
PSYCHOLOGIC		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel safe at home?
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety?
<input type="checkbox"/>	<input type="checkbox"/>	Little interest or pleasure in doing things?
<input type="checkbox"/>	<input type="checkbox"/>	Feeling down, depressed or hopeless?
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts?
<input type="checkbox"/>	<input type="checkbox"/>	Social problems that you feel interfere with your mental or physical health?
If you use alcohol or other recreational drugs		
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever tried to cut down or change your use?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been angered or annoyed by people confronting your use?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt guilty about your use or consequences of your use?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used first thing in the morning as an "eye opener"?
INFECTIONS		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel you are at risk for HIV infection?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been exposed to or treated for tuberculosis?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a blood transfusion?
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent night sweats?
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases?
ENDOCRINE		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination? (If yes, how many times do you get up at night to urinate?)
<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst?
<input type="checkbox"/>	<input type="checkbox"/>	Skin, hair or fingernail changes?
<input type="checkbox"/>	<input type="checkbox"/>	Hot or cold intolerance?
GYNECOLOGIC (female)		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you still having menstrual periods? If YES , when was your last menstrual period? _____ If NO , at what age did your periods stop? _____
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding differing from your regular menstrual flow?
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge?
<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse?
<input type="checkbox"/>	<input type="checkbox"/>	New breast lumps?
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smears? Date of last pap smear?
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal mammograms? Date of last mammogram?
PREVENTION SCREENING		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise on a regular basis (at least 3 times per week)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you believe you eat a varied, balanced diet?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a tetanus shot within the last 10 years? If so, when?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had the pneumonia vaccine (Pneumovax)? If so, when?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sigmoidoscopy or colonoscopy? If so, when?
<input type="checkbox"/>	<input type="checkbox"/>	Do you see any other doctors on a regular basis? If so, who and when?

NAME: _____

DATE: _____

PROVIDER REVIEW: _____