Name: **Date:**

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers in the 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 heat	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 ______________________________		

Hematological/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)

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

Physician: ______________________________________ Date: _____/_____/_____