PATIENT REVIEW OF SYSTEMS

Please check the "**current"** box for all conditions that you are now experiencing and mark the "**recent"** box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked "**Doctor's Notes Only**".

	Current	Recent	**Doctor's Notes Only** Please do not write in this space.
GENERAL			
Fever	☐	☐	
Sweats	☐	☐	
Chills	☐	☐	
Fatigue	☐	☐	
Weight loss	☐	☐	
Weight gain	☐	☐	
Sleep disturbance	☐	☐	
Change in routine	☐	☐	
HEAD			
Headache	☐	☐	
Dizziness	☐	☐	
Head trauma	☐	☐	
Fainting	☐	☐	
Blacking out	☐	☐	
EYES			
Change in vision	☐	☐	
Glasses/Contacts	☐	☐	
Blurry vision	☐	☐	
Double vision	☐	☐	
Cataracts	☐	☐	
Sensitive to light	☐	☐	
Flashes in vision	☐	☐	
Spots in vision	☐	☐	
EARS			
Ringing in ears	☐	☐	
Frequent infection	☐	☐	
Hearing loss	☐	☐	
Drainage	☐	☐	
Ear pain	☐	☐	
NOSE			
Post nasal drip	☐	☐	
Nosebleeds	☐	☐	
Sinus problems	☐	☐	
MOUTH			
Bleeding gums	☐	☐	
Cold sores	☐	☐	
Dentures	☐	☐	
Trouble Swallowing	☐	☐	
Sore throat	☐	☐	
Jaw pain	☐	☐	
Changes in taste	☐	☐	
Swelling	☐	☐	
Dental problems	☐	☐	
Hoarseness	☐	☐	
NECK			
Masses	☐	☐	
Swelling	☐	☐	
Stiffness	☐	☐	

	Current	Recent	**Doctor's Notes Only** Please do not write in this space.
LUNGS			
Difficulty breathing	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Wheezing	☐	☐	
Persistent cough	☐	☐	
Coughing up phlegm	☐	☐	
Coughing up blood	☐	☐	
Tuberculosis	☐	☐	
VASCULAR			
Chest pain	☐	☐	
Palpitations	☐	☐	
Ankle swelling	☐	☐	
Cold feet or hands	☐	☐	
Discolored foot/hand	☐	☐	
Hot feet or hands	☐	☐	
Leg cramps	☐	☐	
Calf pain	☐	☐	
Varicose veins	☐	☐	
Low blood pressure	☐	☐	
High blood pressure	☐	☐	
G-I SYSTEM	☐	☐	
Gas	☐	☐	
Heartburn/Indigestion	☐	☐	
Ulcers	☐	☐	
Vomiting/Nausea	☐	☐	
Abdominal pain	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Blood in stool	☐	☐	
Hemorrhoids	☐	☐	
Gall bladder disease	☐	☐	
Liver disease	☐	☐	
G-U SYSTEM			
Difficulty urinating	☐	☐	
Pain urinating	☐	☐	
Blood in urine	☐	☐	
Incontinence	☐	☐	
Foul odor of urine	☐	☐	
Increased urination	☐	☐	
Decreased urination	☐	☐	
Urinary infection	☐	☐	
Genital infection	☐	☐	
Kidney stones	☐	☐	

Patient Name

Doctor's Name Dr. **Date**

Please turn the page over and complete the checklist on the reverse side before returning to the receptionist.

	Current	Recent	Doctor's Notes Only Please do not write in this space.
PSYCHOLOGIC			
Excessive Stress	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Mood swings	☐	☐	
SKIN	☐	☐	
Rash	☐	☐	
Bruising	☐	☐	
Hair loss	☐	☐	
Warts	☐	☐	
Brittle nails	☐	☐	
Changes in moles	☐	☐	
Itching	☐	☐	
Peeling	☐	☐	
NEUROLOGIC			
Seizures/Epilepsy	☐	☐	
Strokes	☐	☐	
Tingling sensation	☐	☐	
Numbness	☐	☐	
Weakness	☐	☐	
Difficulty walking	☐	☐	
Poor coordination	☐	☐	
MUSCLE/BONE			
Joint pain	☐	☐	
Stiffness	☐	☐	
Muscle ache	☐	☐	
Arthritis	☐	☐	
Deformity	☐	☐	
Bone pain	☐	☐	
Fractures	☐	☐	
Dislocations	☐	☐	
CONDITIONS			
Hypertension	☐	☐	
Diabetes	☐	☐	
Thyroid condition	☐	☐	
Heart condition	☐	☐	
Rheumatic arthritis	☐	☐	
Rheumatic Fever	☐	☐	
Glaucoma	☐	☐	
Alcoholism	☐	☐	
Cancer / Tumor	☐	☐	
Polio	☐	☐	
Parkinson's	☐	☐	
Multiple Sclerosis	☐	☐	
Gout	☐	☐	
Anemia	☐	☐	
Osteoporosis	☐	☐	
VACCINATIONS	**IF AGE > 60 y/o**		
Flu	☐	☐	
Varicella	☐	☐	
Pneumonia	☐	☐	
SCREENING	**IF AGE > 50 y/o**		
Colonoscopy			(List Last Date)
Prostate (Male)			(List Last Date)
Mammogram (Female)			(List Last Date)

	Current	Recent	Doctor's Notes Only Please do not write in this space.
MEDICATION			
Prescription medications	☐	☐	(please bring a list)
Non-prescribed medication.	☐	☐	(please bring a list)
Drug allergies	☐	☐	
Recreational drugs	☐	☐	
MEDICAL	☐	☐	
Surgery-any area	☐	☐	
Hospitalization	☐	☐	
Prior prescriptions	☐	☐	
Psychiatric care	☐	☐	
Substance abuse	☐	☐	
Last laboratory test	☐	☐	
Last chest x-ray (for those over age 55)			
SOCIAL			
Consume alcohol	☐	☐	
Consume coffee	☐	☐	
Consume tea	☐	☐	
Consume sodas	☐	☐	
Smoker	☐	☐	
Aerobic exercise	☐	☐	
Weight-training	☐	☐	
Herbs	☐	☐	
Hobbies	☐	☐	
Vitamins (bring a list)	☐	☐	
Allergies	☐	☐	
Drink glasses water/day			
Sleep hours/night			
OB GYN – For Females	**List Dates as Indicated**		
Age period began			
Last breast exam			
Last PAP date			
Pregnancy(s)- past			
Pregnancy	☐	☐	
Mastectomy	☐	☐	
Lumps in breast	☐	☐	
Nipple discharge	☐	☐	
Hysterectomy	☐	☐	
PMS/ Menstrual cramps	☐	☐	
Irregular periods	☐	☐	
Hot flashes	☐	☐	
Menopause (If Yes List Date)			
FAMILY HISTORY	**Yes**		
Breast Cancer	☐		
Colorectal Cancer	☐		
Alcoholism	☐		
Osteoporosis	☐		
Depression	☐		
Epilepsy	☐		
Alzheimer's	☐		
Heart Disease	☐		
Diabetes	☐		
Other	☐		