# Review of Systems

- Answering these questions will help your doctor understand your health and how to best treat you.
- If you need help filing out this form:
  - Bring this form with you to your appointment and the clinic staff will help you, OR
  - Call the clinic before your appointment and someone will help you over the phone

**We look forward to seeing you soon!**

Name:_____
First Last

Today's Date: _____ Date of Birth:_____

**Circle YES for all that apply during the PAST TWO WEEKS**

| **General** | | |
|---|---|---|
| ☐ **ALL NORMAL** | Has your activity changed recently? | YES |
| | Has your appetite (how much food you eat) changed? | YES |
| | Have you been having chills? | YES |
| | Have you been sweating? | YES |
| | Do you fatigue (get tired) easily? | YES |
| | Do you have a fever? | YES |
| | Has your weight changed in the last year without trying? | YES |

| **Ear, Nose and Throat** | **Do you have the following?** | |
|---|---|---|
| | Congestion (stuffy nose) | YES |
| | Dental problem (teeth) | YES |
| | Drooling | YES |
| | Ear discharge (fluid leaking from your ear) | YES |
| | Ear pain | YES |
| | Swelling in your face | YES |
| | Hearing loss | YES |
| | Mouth sores | YES |
| | Nosebleeds | YES |
| **Continued…** | Postnasal drip (mucus that runs down your throat) | YES |

| | | |
|---|---|---|
| ☐ **ALL NORMAL** | Rhinorrhea (runny nose) | YES |
| | Sinus pain | YES |
| | Sinus pressure | YES |
| | Sneezing | YES |
| | Sore throat | YES |
| | Tinnitus (ringing in ears) | YES |
| | Trouble Swallowing | YES |
| | Voice changes | YES |

| **Eyes** | **Do you have the following?** | |
|---|---|---|
| ☐ **ALL NORMAL** | Eye discharge (fluid leaking out of your eye) | YES |
| | Eye itching | YES |
| | Eye pain | YES |
| | Eye redness | YES |
| | Photophobia (eyes sensitive to light) | YES |
| | Visual Disturbance (blurry vision, halos, blind spots) | YES |

| **Breathing** | **Do you have the following?** | |
|---|---|---|
| ☐ **ALL NORMAL** | Apnea (breathing pauses) | YES |
| | Chest tightness | YES |
| | Choking | YES |
| | Cough | YES |
| | Shortness of breath | YES |
| | Stridor (noisy breathing, musical breathing) | YES |
| | Wheezing (high-pitched whistling sound when breathing) | YES |

| **Heart and Blood Vessels** | **Do you have the following?** | |
|---|---|---|
| ☐ **ALL NORMAL** | Chest pain | YES |
| | Leg Swelling | YES |
| | Palpitations (heart beats fast) | YES |

| **Stomach area** | **Do you have the following?** | |
|---|---|---|
| **Continued…** | Distention (stomach swelling) | YES |
| | Stomach pain | YES |
| | Anal bleeding (bleeding from your bottom) | YES |

| | | |
|---|---|---|
| ☐ **ALL NORMAL** | Blood in your bowel movement (stool) | YES |
| | Constipation (not having as many bowel movement as usual) | YES |
| | Diarrhea (runny bowel movement) | YES |
| | Nausea | YES |
| | Rectal pain (pain in your bottom) | YES |
| | Vomiting (throwing up) | YES |

| **Endocrine** | **Do you have the following?** | |
|---|---|---|
| ☐ **ALL NORMAL** | Cold intolerance | YES |
| | Heat intolerance | YES |
| | Polydipsia (excessive thirst) | YES |
| | Polyphagia (excessive hunger) | YES |
| | Polyuria (frequent urination) | YES |

**WOMEN – complete this section. Men - please SKIP to next section.**

| **Genital and Urinary System** | **Do you have the following?** | |
|---|---|---|
|  ☐**ALL NORMAL** | Problems urinating (peeing) | YES |
| | Dyspareunia (pain when you have sex) | YES |
| | Dysuria (pain when peeing) | YES |
| | Enuresis (bed wetting) | YES |
| | Flank Pain (pain in your side) | YES |
| | Frequency (having to urinate more often than usual) | YES |
| | Genital Sore | YES |
| | Hematuria (blood in your urine) | YES |
| | Problems when you have your menstrual period | YES |
| | Pain in your pelvic area | YES |
| | Urgency (sudden feeling that you have to pee now) | YES |
| | Not peeing as often as you normally do | YES |
| | Vaginal bleeding | YES |
| | Discharge (fluid leaking from your vagina) | YES |
| | Vaginal pain | YES |

**MEN – complete this section. Women - please SKIP to next section.**

| Genital and Urinary System | Do you have the following? | |
|---|---|---|
|  ☐ **ALL NORMAL** | Problems urinating (peeing) | YES |
| | Dysuria (pain with peeing) | YES |
| | Enuresis (peeing at night when you don't mean to) | YES |
| | Flank pain (pain in your side) | YES |
| | Frequency (having to urinate more often than usual) | YES |
| | Genital sore | YES |
| | Hematuria (blood in your urine) | YES |
| | Penis discharge (fluid leaking from your penis) | YES |
| | Penis pain | YES |
| | Penis swelling | YES |
| | Scrotal swelling | YES |
| | Testicular pain | YES |
| | Urgency (sudden feeling that you have to pee now) | YES |
| | Not peeing as often as you normally do | YES |

| Muscles and Joints | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Arthralgias (body aches and pains) | YES |
| | Back pain | YES |
| | Gait (balance problems when you are standing or walking) | YES |
| | Joint swelling (some joints are knee, elbow, wrist) | YES |
| | Myalgia (muscle pain) | YES |
| | Neck pain | YES |
| | Neck stiffness | YES |

| Skin | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Skin color change | YES |
| | Pallor (skin is lighter than usual due to illness) | YES |
| | Rash | YES |
| | Wound | YES |

| Allergies | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Environmental allergies (pollen, dust, pets, mold, etc.) | YES |
| | Food allergies (nuts, milk wheat, fish, etc.) | YES |
| | Immunocompromised (high risk for infection) | YES |

| Head, Balance and Weakness | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Dizziness | YES |
| | Facial asymmetry (face drooping) | YES |
| | Headaches | YES |
| | Lightheadedness | YES |
| | Numbness | YES |
| | Seizures | YES |
| | Problems talking | YES |
| | Syncope (fainting) | YES |
| | Tremors (body shaking) | YES |
| | Weakness | YES |

| Blood | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Adenopathy (large or swollen lymph nodes) | YES |
| | Bruises and bleeds easily | YES |

| Other | Do you have the following? | |
|---|---|---|
| ☐ **ALL NORMAL** | Agitation | YES |
| | Behavior problems | YES |
| | Confusion | YES |
| | Hard time concentrating | YES |
| | Dysphoric mood (depression | YES |
| | Hallucinations (seeing things that are not really there) | YES |
| | Hyperactive (overly active) | YES |
| | Nervous or anxious | YES |
| | Injured yourself on purpose | YES |
| | Sleep disturbance (problems with sleeping) | YES |
| | Have thoughts of killing yourself | YES |