Review of Systems

Name _____ **Today's Date** _____

Please take time to answer the following. The information will assist your doctor in treating your condition. If you have had any of the following in the **past 6 - 12 months**, please **Circle** or **Write Out Your Response**:

Any new medical conditions? (Y / N) Explain:

Any changes to your medications? (Y / N) Explain:

Any new allergies? (Y / N) Explain:

Any new family health conditions? (Y / N) Explain:

Constitutional - none
- fever
- weight loss
- chronic fatigue

Eyes - none
- change in vision
- double vision
- glaucoma

Ears, Nose, Throat - none
- ringing in the ears
- sinus problems
- sore throat

Cardiovascular - none
- heart palpitations
- leg pain with walking
- swelling of the ankles

Gastrointestinal - none
- nausea / vomiting
- constipation / diarrhea
- black / bloody stools

Respiratory - none
- cough
- bloody sputum
- wheezing

Immunologic - none
- hives
- itching
- hayfever

Muskuloskeletal - none
- pain in the joints
- pain in the back / neck
- back strain

Psychiatric - none
- change in sleeping habits
- depression
- anxiety

Skin - none
- rashes
- skin lesions
- change in fingernails

Neurologic - none
- numbness
- tingling
- tremors

Hematologic - none
- bleeding
- clotting problems
- enlarged lymph nodes

Endocrine - none
- dry skin
- hot flashes
- excessive thirst
- night sweats
- breast discharge

Gynecologic - none
- endometriosis
- menopause
- vaginal bleeding
- heavy or painful menses
- number of pregnancies_____ , number of deliveries_____