REVIEW OF SYSTEMS

Name:______________________________ Date:____________

Do you now or have you had any of the following problems? Circle **Y** for Yes or **N** for No.

Please explain any Yes answers in the space provided.

GENERAL:			**GASTROINTESTINAL:**		
Weight loss	Y	N	Recent indigestion	Y	N
Recent fever	Y	N	Recent heartburn	Y	N
			Abdominal pain	Y	N
ENDOCRINE:			Recent nausea	Y	N
Thyroid trouble	Y	N	Recent vomiting	Y	N
Diabetes	Y	N	Gall stones	Y	N
			Ulcer	Y	N
RESPIRATORY:			Severe constipation	Y	N
Asthma	Y	N	Recent Diarrhea	Y	N
Recent coughing	Y	N	Bloody stools	Y	N
Recent coughing up			Black stools	Y	N
phlegm	Y	N	Hemorrhoids	Y	N
Coughing blood	Y	N	Hepatitis	Y	N
Shortness of Breath	Y	N	Jaundice	Y	N
CARDIOVASCULAR:			**HEMATOLOGICAL:**		
High blood pressure	Y	N	Anemia	Y	N
Heart attack	Y	N	Bleeding problems	Y	N
Heart murmur	Y	N	Blood clots	Y	N
Rheumatic fever	Y	N	Gout	Y	N
Ankle swelling	Y	N			
Chest pains	Y	N	**DERMATOLOGICAL:**		
Heart Palpitations	Y	N			
Leg muscle pain when			Recent rash	Y	N
walking	Y	N	Recent itching	Y	N
NEUROLOGICAL:			**UROLOGICAL:**		
Convulsions	Y	N	Kidney stones	Y	N
Stroke	Y	N	Bloody urine	Y	N
Paralysis	Y	N	Bladder infections	Y	N
Seizures	Y	N	Kidney infections	Y	N
Head Injuries	Y	N	Burning during urination	Y	N
Back injuries	Y	N	Frequent urination	Y	N
Back surgery	Y	N	Urine retention	Y	N
FEMALE GENITAL:			**PSYCHOLOGICAL:**		
Menstrual problems	Y	N	Satisfied with life	Y	N
Vaginal discharge	Y	N	Depression	Y	N
Breast lump	Y	N	Considered suicide	Y	N
			Tired	Y	N
			Nervousness	Y	N
MUSCULOSKELATAL ;			**Sexual:**		
Arthritis	Y	N	Sexual Problems	Y	N
Neck pain	Y	N	Genital Herpes/ Sores	Y	N
Back pain	Y	N	Sexual Abuse	Y	N
			Impotence	Y	N
			Premature Ejaculation	Y	N

Init	Date

#Answer	Level of service
0-1	1 or 2
2-9	3
10+	4 or 5

Rev 4/04 Copyright © 2001 by UGNM