

# 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.

<p><b><u>GENERAL:</u></b></p> <p>Weight loss                    Y   N Recent fever                    Y   N</p> <hr/> <p><b><u>ENDOCRINE:</u></b></p> <p>Thyroid trouble                Y   N Diabetes                         Y   N</p> <hr/> <p><b><u>RESPIRATORY:</u></b></p> <p>Asthma                         Y   N Recent coughing                Y   N Recent coughing up phlegm                         Y   N Coughing blood                Y   N Shortness of Breath            Y   N</p> <hr/> <p><b><u>CARDIOVASCULAR:</u></b></p> <p>High blood pressure         Y   N Heart attack                    Y   N Heart murmur                 Y   N Rheumatic fever               Y   N Ankle swelling                Y   N Chest pains                    Y   N Heart Palpitations            Y   N Leg muscle pain when walking                         Y   N</p> <hr/> <p><b><u>NEUROLOGICAL:</u></b></p> <p>Convulsions                    Y   N Stroke                          Y   N Paralysis                        Y   N Seizures                         Y   N Head Injuries                 Y   N Back injuries                  Y   N Back surgery                    Y   N</p> <hr/> <p><b><u>FEMALE GENITAL:</u></b></p> <p>Menstrual problems         Y   N Vaginal discharge            Y   N Breast lump                    Y   N</p> <hr/> <p><b><u>MUSCULOSKELATAL :</u></b></p> <p>Arthritis                        Y   N Neck pain                        Y   N Back pain                        Y   N</p>	<p><b><u>GASTROINTESTINAL:</u></b></p> <p>Recent indigestion            Y   N Recent heartburn              Y   N Abdominal pain                Y   N Recent nausea                 Y   N Recent vomiting               Y   N Gall stones                     Y   N Ulcer                             Y   N Severe constipation         Y   N Recent Diarrhea                Y   N Bloody stools                  Y   N Black stools                    Y   N Hemorrhoids                    Y   N Hepatitis                        Y   N Jaundice                        Y   N</p> <hr/> <p><b><u>HEMATOLOGICAL:</u></b></p> <p>Anemia                         Y   N Bleeding problems            Y   N Blood clots                    Y   N Gout                             Y   N</p> <hr/> <p><b><u>DERMATOLOGICAL:</u></b></p> <p>Recent rash                    Y   N Recent itching                 Y   N</p> <hr/> <p><b><u>UROLOGICAL:</u></b></p> <p>Kidney stones                 Y   N Bloody urine                    Y   N Bladder infections            Y   N Kidney infections             Y   N Burning during urination    Y   N Frequent urination            Y   N Urine retention                Y   N</p> <hr/> <p><b><u>PSYCHOLOGICAL:</u></b></p> <p>Satisfied with life            Y   N Depression                    Y   N Considered suicide            Y   N Tired                            Y   N Nervousness                  Y   N</p> <hr/> <p><b><u>Sexual:</u></b></p> <p>Sexual Problems              Y   N Genital Herpes/ Sores        Y   N Sexual Abuse                  Y   N Impotence                      Y   N Premature Ejaculation        Y   N</p>
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#Answer	Level of service
0-1	1 or 2
2-9	3
10+	4 or 5

Init	Date