Review of Systems

Please check if you have or have had problems related to the areas indicated.

Name _____ Date _____

Constitutional	Yes	No
Fatigue	☐	☐
Sweats	☐	☐
Weight Change	☐	☐
Eyes		
Vision Change	☐	☐
Ear, Nose, Throat		
Dizziness	☐	☐
Gum Bleeding	☐	☐
Nose bleeding	☐	☐
Skin		
Cancers	☐	☐
Rash	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Neurologic		
Head Injury	☐	☐
Numbness	☐	☐
Urinary System		
Kidney Stones	☐	☐
Incontinence	☐	☐
Prostate problems	☐	☐
UTI/Bladder Infections	☐	☐

Endocrine System	Yes	No
Anabolic Steroids	☐	☐
Hormone Treatment	☐	☐
Thyroid Problem	☐	☐
Respiratory		
Bronchitis	☐	☐
Chronic cough	☐	☐
Pneumonia	☐	☐
Shortness of breath	☐	☐
Gastrointestinal		
Blood in stool	☐	☐
Diarrhea/constipation	☐	☐
Gallbladder disease	☐	☐
Cardiovascular		
Chest pain/Angina	☐	☐
Rheumatic fever	☐	☐
Transfusions	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Breast/Genital		
Genital Infections	☐	☐
Masses	☐	☐
Menopause	☐	☐

Other: _____

_____

The information provided on this form is true and correct to the best of my knowledge.

Patient Signature X _____ **Date** _____

Please complete the back side of this form as well.

In the past have you had any of the following?

Serious illnesses: ___ Yes ___ No (*If yes, please list)* _____

_____

Hospitalizations: ___Yes ___No (*If yes, please list*) _____

_____

Surgeries: ___Yes ___ No *(If yes, please list)*_____

_____

Health Habit: *Check the substances and circle the correct option.*
□ Tobacco (past/present/never) ___ pack(s) per day □ Drugs (past/present/never)
□ Alcohol (past/present/never) □ Caffeine (coffee/tea/cola)

Check if you are have had and are current with the following:
□ Influenza vaccination Date _____ If no, why? (allergy/declined/unavailable)
□ Pneumonia (if over age of 65) Date _____

Diabetic: ___Yes ___No (*if yes please complete the following questions)*
Physician whom treats your diabetes: _____
Date of your last exam with that physician: _____
Most Recent Blood Sugar reading: _____
Most Recent A1C: _____
Have you been diagnosed with Neuropathy? ___Yes ___No

If you are over the age of 65, do you have an Advance Directive or Living Will? ___Yes ___No

Patient Questionnaire:

For what reason are you being seen today? _____

When did this begin? _____

Have you attempted or sought any treatment before today? (*This may include home/self-treatment, i.e.: stretching, icing, or over-the-counter pain medications)* ___Yes ___No

If yes, please explain: _____

Have you reached any level of improvement with the above-mentioned treatment? __Yes __No

Please check the type of pain you are experiencing (*check ALL that apply)?*

___ burning ___aching ___dull ___sharp ___shooting ___electrical ___constant
___worse after activity ___ worse in the morning ___worse with first steps after rest

Please rate your current pain on a scale of 1-10, 10 being the be worst.

1 2 3 4 5 6 7 8 9 10