

REVIEW OF SYSTEMS

GENERAL	YES	NO
Anorexia		
Anxiety		
Appetite changes		
Fever		
Hard of hearing/deaf		
Vision problems/blind		
Weight changes		

CARDIO	YES	NO
Chest pain		
Heart murmur		
Irregular heartbeat		
Poor circulation/Peripheral vascular disease		

RESPIRATORY	YES	NO
Asthma		
Cough		
Pneumonia		
Sleep apnea		
Shortness of breath		
Tuberculosis		
Wheezing		

GI	YES	NO
Constipation		
Diarrhea		
Difficulty swallowing		
Heartburn		
Nausea		
Bloody Stool		
Vomiting		

GU	YES	NO
Incontinence		
Menstrual irregularities		
More than 3 mo. without period		
Pregnant		

MUSCULO/EXT	YES	NO
Difficulty walking		
Leg swelling		
Limp		
Weakness		

SKIN	YES	NO
Raynaud's		
Shingles		
Tattoo		

NERVE	YES	NO
Balance problems		
Dizziness		
Numbness/Tingling		
Tremor		

PSYCH	YES	NO
Anxiety		
Depression		
Insomnia		
Mental illness		
Stress		

HEMATOLOGIC	YES	NO
Anemia		
Bleeding/Bruising tendency		
Past transfusion		

ACCIDENTS/INJURIES (if yes, provide details)

Fractures
Details:
Auto accident
Details:
Sports injury
Details:
Other
Details:

SIGNATURES

Patient Signature
Date _____

Physician Signature
Date _____