

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without authorization to do so.

Last Name: _____ First Name: _____ Date of Birth: _____

Today's Date: _____ Reason For Today's Visit: _____

Review of Systems

Do you now or have you had any problems related to the following systems?

CIRCLE YES OR NO

Constitutional Symptoms (Comments)

Weight Change Y N
Chills Y N
Sleep Disorder Y N
Other _____

Eyes

Double Vision Y N
Glaucoma Y N
Cataracts Y N
Other _____

Ear/Nose/Throat/Mouth

Hearing changes Y N
Sore Throat Y N
Sinus problem Y N
Other _____

Cardiovascular

Chest Pain Y N
Irregular Heartbeat Y N
Swelling in ankles Y N
Leg pain upon walking Y N
(Intermittent Claudication)

Psychological

Are you generally happy Y N
Do you feel depressed? Y N
Do you feel anxious? Y N
Do you feel safe in your home? Y N

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Bruising Y N
Other _____

Allergic/Immunologic

Hay Fever Y N
Drug allergies Y N
Food allergies Y N
Other _____

Genitourinary (Comments)

Change in stream Y N
Do you get up at night to urinate Y N
Urinary frequency > 8 times/day Y N
Urinary Urgency Y N
Wear pads for protection Y N

Musculoskeletal

Bone pain Y N
Muscle pain Y N
Joint pain Y N
Other _____

Integumentary (Skin)

Rash Y N
Lumps or bumps Y N
Moles, skin tags Y N
Other _____

Neurological

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Sexual History

Change in sex drive? Y N
Sexual performance satisfaction Y N
Other (i.e. sexual trauma) Y N
History of sexually transmitted diseases Y N

Previous Exams – Dates Requested

Last eye exam: _____ Last Tetanus shot: _____
Last Dental exam: _____ Last Pap: _____
Last mammogram: _____
Last colon exam: _____