

Entira Family Clinics
Review of Systems (ROS)

(Please complete the form by checking the boxes that you have current concerns about.)

Today's Date: _____

Patient Name: _____

DOB: _____

Constitutional	<input type="checkbox"/> Fever <input type="checkbox"/> Significant weight change <input type="checkbox"/> Significant appetite change	Urology	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary urgency
Eye	<input type="checkbox"/> Vision problems <input type="checkbox"/> Eye irritation <input type="checkbox"/> Eye pain	Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Low back pain <input type="checkbox"/> Neck pain
ENT	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Cold symptoms <input type="checkbox"/> Voice changes <input type="checkbox"/> Hearing problems	Neurology	<input type="checkbox"/> Chronic headache <input type="checkbox"/> Passing out <input type="checkbox"/> Confusion <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness
Respiratory	<input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Loud snoring /stop breathing when sleeping	Dermatology	<input type="checkbox"/> Rash <input type="checkbox"/> Worrisome moles <input type="checkbox"/> Skin lesions
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Palpitations (racing heart or skipped beats)	Mental Health	<input type="checkbox"/> Sadness <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Do you feel unsafe?
Gastroenterology	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools	Endocrinology	<input type="checkbox"/> Feeling too cold or too hot <input type="checkbox"/> Frequently thirsty
Male Reproductive	<input type="checkbox"/> Concern for Sexually Transmitted Disease (STD) <input type="checkbox"/> Testicular lump/pain <input type="checkbox"/> Penile discharge or lump <input type="checkbox"/> Problems with sexual function	Hematology – Oncology	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Easy bruising
Female Reproductive	<input type="checkbox"/> Concern for Sexually Transmitted Disease (STD) <input type="checkbox"/> Breast lumps, breast concerns <input type="checkbox"/> Abnormal vaginal discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Menstrual cycle concerns	Additional Information	I have an Advance Directive <input type="checkbox"/> Yes <input type="checkbox"/> No I am an Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No I am interested in discussing: <input type="checkbox"/> Advance Directive <input type="checkbox"/> Organ donation