PATIENT REVIEW OF SYSTEMS

Please check the "**current"** box for all conditions that you are now experiencing and mark the "**ever"** box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked "**Doctor's Notes Only**".

	Current	Ever	Doctor's Notes Only Please do not write in this space.
GENERAL			
Fever	☐	☐	
Sweats	☐	☐	
Chills	☐	☐	
Fatigue	☐	☐	
Weight loss	☐	☐	
Weight gain	☐	☐	
Sleep disturbance	☐	☐	
Change in routine	☐	☐	
HEAD			
Headaches	☐	☐	
Dizziness	☐	☐	
Head trauma	☐	☐	
Fainting	☐	☐	
Migraines	☐	☐	
EYES			
Change in vision	☐	☐	
Blurry/Double vision	☐	☐	
Flashes/Spots	☐	☐	
Sensitive to light	☐	☐	
Cataracts	☐	☐	
EARS			
Ringing in ears	☐	☐	
Frequent infection	☐	☐	
Hearing loss	☐	☐	
Ringing in ears	☐	☐	
Ear pain	☐	☐	
NOSE			
Post nasal drip	☐	☐	
Nosebleeds	☐	☐	
Sinus problems	☐	☐	
MOUTH			
Trouble Swallowing	☐	☐	
Sore throat	☐	☐	
Jaw pain	☐	☐	
Changes in taste	☐	☐	
Dental problems	☐	☐	
NECK			
Swelling	☐	☐	
Stiffness	☐	☐	
PSYCHOLOGIC			
Excessive Stress	☐	☐	
Depression	☐	☐	
Stress	☐	☐	
Mood swings	☐	☐	
VACCINATIONS			
Flu	☐	☐	
Varicella	☐	☐	
Pneumonia	☐	☐	

	Current	Ever	Doctor's Notes Only Please do not write in this space.
LUNGS			
Difficulty breathing	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Wheezing	☐	☐	
Persistent cough	☐	☐	
VASCULAR			
Blood clots	☐	☐	
Heart attack	☐	☐	
High cholesterol	☐	☐	
Chest pain	☐	☐	
Poor circulation	☐	☐	
Ankle swelling	☐	☐	
Cold/Hot feet or hands	☐	☐	
Aortic Aneurism	☐	☐	
Hot feet or hands	☐	☐	
Leg cramps	☐	☐	
Calf pain	☐	☐	
Varicose veins	☐	☐	
Low blood pressure	☐	☐	
High blood pressure	☐	☐	
Pace Maker	☐	☐	
Irregular Heartbeat	☐	☐	
G-I SYSTEM			
Ulcers	☐	☐	
Vomiting/Nausea	☐	☐	
Abdominal pain	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Gas	☐	☐	
Heartburn/Indigestion	☐	☐	
G-U SYSTEM	☐	☐	
Difficulty urinating	☐	☐	
Pain urinating			
Blood in urine	☐	☐	
Incontinence	☐	☐	
Foul odor of urine	☐	☐	
Increased urination	☐	☐	
Decreased urination	☐	☐	
Urinary/Kidney infection	☐	☐	
Kidney stones	☐	☐	
Difficulty starting or stopping urination	☐	☐	

Patient Name _____

Doctor's Name_____ **Date** _____

Please turn the page over and complete the checklist on the reverse side before handing this page to your intern.

	Curren	Ever	Doctor's Notes Only Please do not write in this space.
MEDICAL			
Hospitalization	☐	☐	
Prior prescriptions	☐	☐	
Psychiatric care	☐	☐	
Substance abuse	☐	☐	
SKIN			
Rash	☐	☐	
Bruising	☐	☐	
Hair loss	☐	☐	
Warts	☐	☐	
Brittle nails	☐	☐	
Changes in moles	☐	☐	
Itching	☐	☐	
Peeling	☐	☐	
NEUROLOGIC			
Seizures/Epilepsy	☐	☐	
Strokes	☐	☐	
Tingling sensation	☐	☐	
Numbness	☐	☐	
Weakness	☐	☐	
Difficulty walking	☐	☐	
Poor coordination	☐	☐	
Numbness	☐	☐	
MUSCLE/BONE			
Joint pain	☐	☐	
Stiffness	☐	☐	
Muscle ache	☐	☐	
Arthritis	☐	☐	
Muscle weakness	☐	☐	
Fractures	☐	☐	
Dislocations	☐	☐	
CONDITIONS			
Hypertension	☐	☐	
Diabetes	☐	☐	
Thyroid condition	☐	☐	
Heart condition	☐	☐	
Rheumatic arthritis	☐	☐	
Rheumatic Fever	☐	☐	
Glaucoma	☐	☐	
Alcoholism	☐	☐	
Cancer / Tumor	☐	☐	
Polio	☐	☐	
Parkinson's	☐	☐	
Multiple Sclerosis	☐	☐	
Gout	☐	☐	
Anemia	☐	☐	
Osteoporosis	☐	☐	

	Curren	Ever	Doctor's Notes Only Please do not write in this space.
MEDICATION			
Prescription medications	☐	☐	(please bring a list).
Non-prescribed medication.	☐	☐	(please bring a list)
Drug allergies	☐	☐	
Recreational drugs	☐	☐	
FAMILY HISTORY			
Breast Cancer	☐	☐	
Colorectal Cancer	☐	☐	
Alcoholism	☐	☐	
Osteoporosis	☐	☐	
Depression	☐	☐	
Epilepsy	☐	☐	
Alzheimer's	☐	☐	
Heart Disease	☐	☐	
SOCIAL			
Consume alcohol	☐	☐	
Consume coffee	☐	☐	
Consume tea	☐	☐	
Consume sodas	☐	☐	
Smoker	☐	☐	
Aerobic exercise	☐	☐	
Water intake/day	☐	☐	
Vitamins	☐	☐	
Allergies	☐	☐	
Drink ___ glasses water/day	☐	☐	
Sleep _____ hours/night	☐	☐	
OB GYN – For Females			**List Dates as Indicated**
Pregnancy(s)- past			_____
Pregnancy			_____
Mastectomy			_____
Lumps in breast			_____
Hysterectomy	☐	☐	
PMS	☐	☐	
Irregular periods	☐	☐	
Hot flashes	☐	☐	
Menstrual cramps	☐	☐	
FAMILY HISTORY			
Breast Cancer	☐	☐	
Colorectal Cancer	☐	☐	
Alcoholism	☐	☐	
Osteoporosis	☐	☐	
Depression	☐	☐	
Alzheimer's	☐	☐	
Heart Disease	☐	☐	