



NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Constitutional

Recent weight change Y__N__
Fever Y__N__
Fatigue Y__N__
Eyes Y__N__
Blurred vision Y__N__
Glaucoma Y__N__

Cardiovascular

Chest pain Y__N__
Shortness of breath Y__N__
Swelling of ankles Y__N__

Respiratory

Chronic Cough Y__N__
Spitting Blood Y__N__
Wheezing Y__N__

Genitourinary

Burning with urination Y__N__
Blood in urine Y__N__

Musculoskeletal

Joint pain/swelling Y__N__
Back pain Y__N__
Muscle pain Y__N__

Skin

Rash Y__N__
Itching Y__N__

Neurological

Headaches Y__N__
Seizures Y__N__
Strokes Y__N__
Numbness Y__N__

Hematological

Bleeding/bruising easily Y__N__
Anemia Y__N__
Past transfusion Y__N__

COMMENTS:

Gastrointestinal

Poor Appetite Y__N__
Difficulty swallowing Y__N__
Heartburn Y__N__
Nausea/Vomiting Y__N__
Bloating Y__N__
Belching Y__N__
Regurgitation Y__N__
Constipation Y__N__
Diarrhea Y__N__
Abdominal pain Y__N__
Recent change in bowels Y__N__
Rectal bleeding Y__N__
Black, tarry stools Y__N__
Recent Pepto Bismol use Y__N__
Excessive hunger Y__N__
Change in stool color Y__N__
Change in stool caliber Y__N__
Stool consistency change Y__N__
Laxative/Antacid use Y__N__
Food intolerance Y__N__
Abdominal size change Y__N__
Hemorrhoids Y__N__
Infections Y__N__
Jaundice Y__N__
Rectal Pain Y__N__
Hepatitis Y__N__
Liver disease Y__N__
Gallbladder disease Y__N__

Psychiatric

Memory loss/confusion Y__N__
Depression Y__N__

Endocrine

Heat/cold intolerance Y__N__
Excessive thirst/urination Y__N__

Are you pregnant? Y__N__
Prior abdominal x-rays Y__N__
Prior blood work Y__N__

REVIEWED (Doctor to Initial)

Date_____By_____

Date_____By_____

Date_____By_____

