



Breathe well. Sleep well. Live well.

REVIEW OF SYSTEMS

Patient Name: _____

- 1. Constitutional: Which of the following have you had? Excessive perspiration/sweats, Fatigue, Weakness, Chills, Fever, Weight loss

- 2. Ophthalmologic (eyes): Which of the following have you had? Failing Vision, Eye Pain, Eye Irritation, Blurring, Double Vision

- 3. Ears, Nose, Mouth, & Throat: Which of the following have you had? Sneezing, Nosebleeds, Sores in the mouth, Sore throat, Hoarseness/change in voice, Choking, Difficulty/Pain in swallowing, Neck Pain, Lumps in the neck, Swelling in the neck

- 4. Cardiovascular (Heart and Circulation): Which of the following have you had? Swelling, Chest Pain, Angina, Passing Out

- Cardiovascular (Heart and Circulation) cont: Dizziness, Palpitations, Shortness of Breath, Leg Cramps

- 5. Respiratory (Lungs): Which of the following have you had? Shortness of breath, Cough, Coughing up blood, Coughing up mucus, Wheezing, Chest pain, Chest congestion

- 6. Gastrointestinal (Stomach and Bowels): Which of the following have you had? Nausea, Vomiting, Diarrhea, Abdominal Pain, Heartburn/Bloating/Bleching, Indigestion, Constipation, Vomiting or passing blood, Yellow jaundice

- 7. Genitourinary (Bladder/Kidney): Which of the following have you had? Many urinations, day or night, Difficulty holding and/or leakage of urine, Blood in urine, Burring with urination

REVIEW OF SYSTEMS cont:

Genitourinary (Bladder/Kidney) cont:

- Decrease in sexual desire
- Weak/slow urine stream
- Inability to have or maintain penile erection (males)

8. Integumentary (Skin):

Which of the following have you had?

- Easy bruising
- Rash
- Itching
- Changes in your nails
- Moles/skin cancer

9. Musculoskeletal (Bone/Joint/Back):

Which of the following have you had?

- Joint aching or pain
- Bone pain
- Joint stiffness
- Joint Swelling
- Muscle pain
- Back pain

10. Neurological (Nervous System):

Which of the following have you had?

- Stroke
- Numbness and/or tingling
- Dizziness
- Loss of Balance
- Head Injury
- Tremor or twitches
- Paralysis
- Muscle weakness
- Memory loss or confusion
- Chronic pain
- Seizures

11. Hematologic/Lymphatic (Blood):

Which of the following have you had?

- Lymph gland swelling or tenderness
- Nosebleeds
- Easy bruising
- Blood in urine
- Anemia
- Blood transfusion

12. Endocrine/Metabolic (Glandular):

Which of the following have you had?

- Weight Change
- Heat intolerance/Hot flashes
- Cold intolerance
- Decrease in sex drive
- Menopause (females)
- Menstrual irregularities (females)
- Breast enlargement/pain

13. Allergic/Immunologic

Which of the following have you had?

- Sneezing
- Hay Fever
- Wheals/Hives
- Bee Sting Allergy
- Allergy testing

14. Psychiatric (Mental):

Which of the following have you had?

- Mood disturbance
- Anxiety/nervousness
- Sleep disturbances
- Inability to concentrate
- Difficulty getting along with others

15. Sleep History

Which of the following have you had?

- Daytime sleepiness
- Daytime fatigue
- Fall asleep driving
- Poor sleep quality
- Waking up tired
- Snoring
- Started shift or night work
- Nightmares
- Nocturnal pain/cramps
- Leg jerks/Cramps

16. All others negative