

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you now or have you had any problems related to the following systems? Please Circle Yes or No and explain any Yes answers in the space provided. If additional space is needed, please use the back of this page. This page must be completed in full prior to consultation with the Doctor.

**CONSTITUTIONAL SYMPTOMS**

Fever Y N  
Chills Y N  
Headache Y N  
Other \_\_\_\_\_

**EYES**

Blurred Vision Y N  
Double Vision Y N  
Pain Y N  
Other \_\_\_\_\_

**ALLERGIC/IMMUNOLOGIC**

Hay Fever Y N  
Drug Allergies Y N  
Other \_\_\_\_\_

**NEUROLOGICAL**

Tremors Y N  
Dizzy Spells Y N  
Numbness/Tingling Y N  
Other \_\_\_\_\_

**ENDOCRINE**

Excessive Thirst Y N  
Too Hot/Cold Y N  
Tired/Sluggish Y N  
Other \_\_\_\_\_

**GASTROINTESTINAL**

Abdominal Pain Y N  
Nausea/Vomiting Y N  
Indigestion/Heartburn Y N Sometimes  
Other \_\_\_\_\_

**CARDIOVASCULAR**

Chest Pain Y N  
Varicose Veins Y N  
High Blood Pressure Y N

**INTEGUMENTARY**

Skin Rash Y N  
Boils Y N  
Persistent Itch Y N  
Other \_\_\_\_\_

**MUSCULOSKELETAL**

Joint Pain Y N  
Neck Pain Y N  
Back Pain Y N  
Other \_\_\_\_\_

**EAR/NOSE/THROAT/MOUTH**

Ear Infection Y N  
Sore Throat Y N  
Sinus Problems Y N  
Other \_\_\_\_\_

**GENITOURINARY**

Urine Retention Y N  
Painful Urination Y N  
Urinary Frequency Y N  
Other \_\_\_\_\_

**RESPIRATORY**

Wheezing Y N  
Frequent Cough Y N  
Shortness of Breath Y N  
Other \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC**

Swollen Glands Y N  
Blood Clotting Problem Y N  
Hepatitis B Y N  
Hepatitis C Y N  
HIV Y N  
Other \_\_\_\_\_

**PSYCHOLOGIC**

Are you Generally Satisfied with your life? Y N  
Do you Feel Severely Depressed? Y N  
Considered Suicide? Y N

Physician Use Only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_