

Medical Review of Systems



Click next to any symptom you have experienced recently, or for which you have concerns. Click again if you wish to remove the checkmark. Please print this form out after its complete and bring it with you to your appointment. If you don't understand something, write a question-mark by it on your print out. Your doctor will discuss any positive responses with you.

Name: _____

Date: _____

General	
<input type="checkbox"/>	Recent unexpected weight loss
<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Lack of regular exercise
<input type="checkbox"/>	Overweight

Pulmonary	
<input type="checkbox"/>	Pneumonia/pleurisy
<input type="checkbox"/>	Bronchitis/chronic cough
<input type="checkbox"/>	Asthma/wheezing

Musculoskeletal	
<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	Pain in muscles
<input type="checkbox"/>	Recurrent back pains
<input type="checkbox"/>	Past injury to bones, spine, or joints
<input type="checkbox"/>	Gout attacks in the past
<input type="checkbox"/>	Concerned about osteoporosis

Endocrine	
<input type="checkbox"/>	Excessive thirst and urination
<input type="checkbox"/>	Feet and hands numbness/pain
<input type="checkbox"/>	Low blood sugar problems
<input type="checkbox"/>	Intolerance to heat or cold

Eyes	
<input type="checkbox"/>	Failing Vision
<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Double Vision
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Frequent eye infections
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Cataracts

Gastrointestinal	
<input type="checkbox"/>	Recent loss of appetite
<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Heartburn/gastritis
<input type="checkbox"/>	Persistent nausea/vomiting
<input type="checkbox"/>	Chronic abdominal pain
<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	Jaundice (yellow skin)
<input type="checkbox"/>	Change in appearance of stool
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Bloody or very black stools
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hernia

Integumentary	
<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Skin moles-black or changing
<input type="checkbox"/>	Breast mass
<input type="checkbox"/>	Nipple discharge

Hematologic / Lymphatic	
<input type="checkbox"/>	Excessive bruising or bleeding
<input type="checkbox"/>	Swollen glands-neck, armpit or groin
<input type="checkbox"/>	Unexplained fever, chills, night sweats

Ears, Nose, Mouth	
<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	Ringing in ear
<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	Frequent nose bleeds
<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	Frequent sore throats
<input type="checkbox"/>	Prolonged hoarseness
<input type="checkbox"/>	Tooth or jaw pain

Genito-Urinary	
<input type="checkbox"/>	Frequent urine infections
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	Loss of control of urine
<input type="checkbox"/>	Decrease in flow
<input type="checkbox"/>	Urination more than 2 times per night
<input type="checkbox"/>	Any venereal disease in the past? (Herpes, Chlamydia, gonorrhea)

Neurologic	
<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	Tremor/hands shaking
<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	Seizures/convulsions
<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	Excessive daytime sleeping
<input type="checkbox"/>	Memory loss

Allergic / Immunologic	
<input type="checkbox"/>	Hay fever/Allergies
<input type="checkbox"/>	Getting lots of infections
<input type="checkbox"/>	Desire HIV discussion

Cardiovascular	
<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Dizzy spells
<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	Shortness of breath

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Psychological	
<input type="checkbox"/>	Feeling depressed
<input type="checkbox"/>	Nervous or anxious feeling
<input type="checkbox"/>	Excessive moodiness
<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	Phobias/unexplained fears
<input type="checkbox"/>	No pleasure in life anymore

Substance/Chemical Use	
<input type="checkbox"/>	More than 6 drinks/week
<input type="checkbox"/>	Use of tobacco products
<input type="checkbox"/>	Caffeine use
<input type="checkbox"/>	Over-the-counter medicine / vitamins

Anything else you want your doctor to be aware of?	
<input type="checkbox"/>	

Women Only	
<input type="checkbox"/>	Periods Irregular
<input type="checkbox"/>	Excessive flow/pain
<input type="checkbox"/>	Hot flashes/night sweats
<input type="checkbox"/>	Abnormal PAP smear