REVIEW OF SYSTEMS – Answer all questions

URINARY
Frequent urination..... No Yes
Burning or painful urination..... No Yes
Blood in urine..... No Yes
Incontinence or dribbling..... No Yes
Sexual difficulty..... No Yes
Male – testicle pain..... No Yes
Male – does regular testicle exams..... No Yes
Male – have you had a prostate exam.. No Yes
Female – pain with periods..... No Yes
Female – irregular periods..... No Yes
Female – vaginal discharge..... No Yes
Female – on birth control..... No Yes
Female – vaginal infection in past..... No Yes
Female – have you had abnormal PAP.. No Yes

SKIN
Rash or itching..... No Yes
Do you do regular breast exams ..... No Yes
Breast pain..... No Yes
Breast lump..... No Yes
Breast discharge..... No Yes

CONSTITUTIONAL
Good general health lately..... No Yes
Recent weight change..... No Yes
Headaches..... No Yes

EYES
Wear glasses/contact lens..... No Yes

ENT
Sinus problems..... No Yes
Sore throat or voice change..... No Yes
Swollen glands in neck..... No Yes

CARDIOVASCULAR
Heart trouble..... No Yes
Chest pains..... No Yes
Sudden heart beat changes..... No Yes
Swelling of feet, ankles or hands..... No Yes

RESPIRATORY
Frequent coughing..... No Yes
Shortness of breath..... No Yes
Asthma or wheezing..... No Yes

GASTROINTESTINAL
Loss of appetite..... No Yes
Change in bowel movements..... No Yes
Nausea or vomiting..... No Yes
Frequent diarrhea..... No Yes
Painful bowel movements/constipation.. No Yes
Blood in stool..... No Yes
Stomach pain..... No Yes

ENDOCRINE
Excessive thirst or urination..... No Yes
Heat or cold intolerance..... No Yes
Dry skin..... No Yes

MUSCULOSKELETAL
Joint pain..... No Yes
Muscle pain or cramps..... No Yes
Back pain..... No Yes

NEUROLOGICAL
Frequent or recurring headaches..... No Yes
Light headed or dizzy..... No Yes
Numbness or tingling sensations..... No Yes

PSYCHIATRIC
Nervousness..... No Yes
Depression..... No Yes
Sleep problems..... No Yes

HEMATOLOGIC/LYMPHATIC
Easily bruise or bleed..... No Yes
Anemia..... No Yes
Phlebitis..... No Yes
Past transfusion..... No Yes

OTHER COMMENTS:

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Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____