NAME _______________________ DATE _____________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

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/too cold y N
- Tired/sluggish y N
- Other

Gastrointestinal
- Abdominal pain y N
- Nausea/vomiting y N
- Indjgestion/heartburn y N
- Other

Cardiovascular
- Chest pain y N
- Varicose veins y N
- High blood pressure y N
- Other

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
- Other

Psychologic
- Are you generally satisfied with your life? y N
- Do you feel severely depressed? y N
- Have you considered suicide? y N
- Other

Physician use only: **(Comments/Notes)**

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