

Review of Systems

Patient Name _____ Date __/__/____

Please check (P) for Past or (C) for Current (if it doesn't apply, leave it black)

P C General History

- Trauma/injuries
- HIV positive
- Allergies
- Malaise/Fatigue

P C Family History

- Diabetes
- Thyroid
- Tuberculosis
- Kidney Disease
- High Blood Pressure
- Heart Disease/Stroke
- Musculoskeletal Disease
- Cancer

P C Eye/Ear/Nose/Throat

- Ringing in ears
- Dizziness
- Ear Pain
- Change in ability to smell
- Sinusitis

P C Urinary System

- Pain on urination
- Difficulty in holding urine
- Discharge
- Urinary Tract Infection
- Kidney disease
- Pelvic Pain/Mass

P C Musculoskeletal System

- Joint Stiffness/pain/swelling
- Muscle cramps/weakness/wasting
- Neck pain
- Mid back pain
- Low back/sacroiliac/tailbone pain
- Arm/leg pain

P C Skin/hair/nails

- Rash/itching/sores
- Changes in moles/growths
- Skin Cancer
- Hair loss
- Change in shape/color of nails

P C Gastrointestinal System

- Nausea/vomiting
- Indigestion/heartburn
- Diarrhea/Constipation

P C Respiratory System

- Difficulty breathing
- Tuberculosis
- Lung disease
- Cigarettes per day ___ / number of yrs___

P C Endocrine System

- Thyroid problems
- Diabetes
- Other _____

P C Cardiovascular System

- Shortness of breath
- Chest pain/discomfort
- Palpitations
- Calf pain
- High blood pressure
- Heart disease
- Cardiac/pacemaker

P C Neurological System

- Seizures
- Changes in sensations
- Unusual Weakness
- Head Trauma
- Stroke

P C Breasts

- Bumps, lumps, mass
- Pain/tenderness

P C Reproductive System

- Genital lesions/sores/mass/pain
- Sexually transmitted disease
- Prostate- last exam _____
- Date of last PAP test _____