

# Review of Systems for established patients

(Please complete both pages)

Name \_\_\_\_\_ Date \_\_\_\_\_

-Please check problem areas and fill in necessary information

**-VERY IMPORTANT**

**PLEASE BRING AN UPDATED MEDICATION LIST EVERY OFFICE VISIT**

<b>Allergic/Immunologic</b>		€ Hives	€ Yes	€ No	
<b>Constitutional</b>					Select grade of fatigue (circle one)
€ Fatigue	€ Yes	€ No	a little	0 1 2 3 4 5 6 7 8 9 10	a lot
€ Fever	High Temp _____	€ Yes	€ No		
€ Weight changes		€ Yes	€ No		
<b>Eyes</b>					
€ Trouble seeing	€ Yes	€ No	□ other	explain _____	
€ Dry Eyes	€ Yes	€ No			
€ Eyes tearing	€ Yes	€ No			
<b>ENT/Mouth</b>					
€ Sore throat	€ Yes	€ No	□ other	explain _____	
€ Dry mouth	€ Yes	€ No			
€ Mouth sores/ulcers	€ Yes	€ No			
€ Trouble swallowing	€ Yes	€ No			
<b>Pain</b>					
€ Physical pain	€ Yes	€ No	(circle one)	little	a lot
				0 1 2 3 4 5 6 7 8 9 10	
	Location _____			How long _____	
€ Headache	€ Yes	€ No			
	Describe _____				
<b>Cardiovascular</b>					
	€ other; explain _____				
€ Rapid heartbeat	€ Yes	€ No			
€ Chest pain	€ Yes	€ No		describe _____	
€ Swelling	€ Yes	€ No		where _____	
<b>Respiratory</b>					
€ Coughing (productive/non-productive)	€ Yes	€ No			
	Sputum color _____				
€ Difficulty breathing/pain with deep breaths	€ Yes	€ No			
€ Coughing up blood	€ Yes	€ No			

**GI**

- € Decrease appetite € Increased appetite
- € Constipation Last BM \_\_\_\_\_ □ other: explain \_\_\_\_\_
- € Nausea € Yes € No Current Nausea Meds \_\_\_\_\_
- € Vomiting € Yes € No How many times last 24 hrs \_\_\_\_\_
- € Diarrhea € Yes € No
- How many stools last 24 hrs \_\_\_\_\_ What are you taking \_\_\_\_\_
- € Heartburn € Yes € No How often \_\_\_\_\_

**Review of Systems Communications Page 2****GU**

- € Problems with urination € Yes € No □ other explain \_\_\_\_\_
- Blood in urine □ burning □ hesitancy □ frequency

**Musculoskeletal**

- € Weakness of body parts € Yes € No where \_\_\_\_\_
- € Muscle Aches € Yes € No
- € Joint pain € Yes € No □ other explain \_\_\_\_\_

**Integumentary (skin/breast)**

- € Dry skin € Yes € No □ other explain \_\_\_\_\_
- € Hair loss € Yes € No
- € Rash € Yes € No
- € Itching € Yes € No
- € Nail changes € Yes € No

**Neurological**

- € Trouble thinking (concentrating) € Yes € No
- € Trouble sleeping at night? € Yes € No

**What meds/techniques have you tried**

- € Dizziness/lightheadedness € Yes € No
- € Daytime sleepiness € Yes € No
- € Burning in hands/feet € Yes € No
- € Numbness/tingling € Yes € No where: \_\_\_\_\_
- € Memory loss □ other explain \_\_\_\_\_

**Endocrine**

- Sexual problems € Yes € No □ other explain \_\_\_\_\_
- Night sweats € Yes € No
- Day sweat € Yes € No

**Hematologic/Lymphatic**

- € Bruising € Yes € No □ other explain \_\_\_\_\_
- € Easy bleeding € Yes € No

**Psychiatric**

- € Sad/Depressed € Yes € No □ other explain \_\_\_\_\_
- € Nervous, tense, anxious € Yes € No
- € Feeling hopeless € Yes € No

Are there any prescriptions you need refilled?      € Yes    € No  
List here: \_\_\_\_\_  
Any other concerns?      € Yes      € No  
List here: \_\_\_\_\_