

PATIENT REVIEW OF SYSTEMS

Please check the “**current**” box for all conditions that you are now experiencing and mark the “**recent**” box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked “**Doctor’s Notes Only**”.

	Current	Recent
GENERAL		
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Change in routine	<input type="checkbox"/>	<input type="checkbox"/>
HEAD		
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>
EYES		
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>
EARS		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
NOSE		
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
MOUTH		
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
NECK		
Masses	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>

Doctor’s Notes Only
Please do not write in this space.

	Current	Recent
LUNGS		
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
Cold feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Discolored foot/hand	<input type="checkbox"/>	<input type="checkbox"/>
Hot feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
G-I SYSTEM		
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
G-U SYSTEM		
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Genital infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

Doctor’s Notes Only
Please do not write in this space.

Patient Name _____

Doctor’s Name _____ **Date** _____

Please turn the page over and complete the checklist on the reverse side before handing this page to your intern.

Doctor's Notes Only

Please do not write in this space.

Current
Recent

PSYCHOLOGIC

- Excessive Stress
- Depression
- Anxiety
- Mood swings

SKIN

- Rash
- Bruising
- Hair loss
- Warts
- Brittle nails
- Changes in moles
- Itching
- Peeling

NEUROLOGIC

- Seizures/Epilepsy
- Strokes
- Tingling sensation
- Numbness
- Weakness
- Difficulty walking
- Poor coordination

MUSCLE/BONE

- Joint pain
- Stiffness
- Muscle ache
- Arthritis
- Deformity
- Bone pain
- Fractures
- Dislocations

CONDITIONS

- Hypertension
- Diabetes
- Thyroid condition
- Heart condition
- Rheumatic arthritis
- Rheumatic Fever
- Glaucoma
- Alcoholism
- Cancer / Tumor
- Polio
- Parkinson's
- Multiple Sclerosis
- Gout
- Anemia
- Osteoporosis

VACCINATIONS

IF AGE > 60 y/o

- Flu
- Varicella
- Pneumonia

Last Prostate Exam _____

Last Colonoscopy _____

Doctor's Notes Only

Please do not write in this space.

Current
Recent

MEDICATION

- Prescription medications (please bring a list).
- Non-prescribed medication. (please bring a list)
- Drug allergies
- Recreational drugs

MEDICAL

- Surgery-any area
- Hospitalization
- Prior prescriptions
- Psychiatric care
- Substance abuse
- Last laboratory test
- Last chest x-ray
- (for those over age 55) _____

SOCIAL

- Consume alcohol
- Consume coffee
- Consume tea
- Consume sodas
- Smoker
- Aerobic exercise
- Water intake/day
- Herbs
- Hobbies
- Vitamins (bring a list)
- Allergies
- Drink _____ glasses water/day
- Sleep _____ hours/night

OB GYN – For Females

List Dates as Indicated

- Age period began _____
- Last breast exam _____
- Last PAP date _____
- Pregnancy(s)- past _____
- Pregnancy
- Mastectomy
- Lumps in breast
- Nipple discharge
- Hysterectomy
- PMS
- Irregular periods
- Hot flashes
- Menstrual cramps

FAMILY HISTORY

- Breast Cancer
- Colorectal Cancer
- Alcoholism
- Osteoporosis
- Depression
- Epilepsy
- Alzheimer's
- Heart Disease
- Diabetes

Other _____
