

# Medical Review of Systems

Check next to any symptoms you have experienced since last visit/recently, or for which you have concerns about.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

BP \_\_\_\_ / \_\_\_\_

P \_\_\_\_

Ht. \_\_\_\_

Wt. \_\_\_\_

006General	
<input type="checkbox"/>	Recent unexpected weight loss
<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Lack of regular exercise
<input type="checkbox"/>	Overweight

Eyes	
<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Frequent eye infections
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Cataracts

Ears, Nose, Mouth	
<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	Frequent nose bleeds
<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	Frequent sore throat
<input type="checkbox"/>	Prolonged hoarseness
<input type="checkbox"/>	Tooth or jaw pain

Cardiovascular	
<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Dizzy spells
<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	Shortness of breath

Pulmonary	
<input type="checkbox"/>	Pneumonia/pleurisy
<input type="checkbox"/>	Bronchitis/chronic cough
<input type="checkbox"/>	Asthma/wheezing

Gastrointestinal	
<input type="checkbox"/>	Recent loss of appetite
<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Heartburn/gastritis
<input type="checkbox"/>	Persistent nausea/vomiting
<input type="checkbox"/>	Chronic abdominal pain
<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Change in appearance of stool
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Bloody or very dark stools
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hernia

Genito-Urinary	
<input type="checkbox"/>	Frequent urine infections
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	Loss of control of urine
<input type="checkbox"/>	Decrease in flow
<input type="checkbox"/>	Urination more than 2x per night
<input type="checkbox"/>	Any venereal disease in the past? (Herpes, Chlamydia, Gonorrhea)

Musculoskeletal	
<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	Pain in muscles
<input type="checkbox"/>	Recurrent back pains
<input type="checkbox"/>	Past injury to bones, spine, or joints
<input type="checkbox"/>	Gout attacks in the past
<input type="checkbox"/>	Concerned about osteoporosis

Integumentary	
<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Skin moles—black or changing
<input type="checkbox"/>	Breast mass
<input type="checkbox"/>	Nipple discharge

Neurologic	
<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	Tremor/hand shaking
<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	Seizures/convulsions
<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	Excessive daytime sleeping
<input type="checkbox"/>	Memory loss

Psychological	
<input type="checkbox"/>	Feeling depressed
<input type="checkbox"/>	Nervous or anxious feeling
<input type="checkbox"/>	Excessive moodiness
<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	Phobias/unexplained fears
<input type="checkbox"/>	Loss of pleasure in life

Endocrine	
<input type="checkbox"/>	Excessive thirst and urination
<input type="checkbox"/>	Feet and hands numbness/pain
<input type="checkbox"/>	Low blood sugar problems
<input type="checkbox"/>	Intolerance to heat or cold

Hematologic/Lymphatic	
<input type="checkbox"/>	Excessive bruising
<input type="checkbox"/>	Swollen glands in neck, armpit, or groin
<input type="checkbox"/>	Unexplained fever, chills, night sweats

Allergic/Immunologic	
<input type="checkbox"/>	Hay fever/allergies
<input type="checkbox"/>	Acquiring many infections
<input type="checkbox"/>	Desire HIV discussion

Substance/Chemical Use	
<input type="checkbox"/>	More than 6 drinks a week
<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	Caffeine use
<input type="checkbox"/>	Over-the-counter meds/vitamins

Women Only	
<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	Excessive flow/pain
<input type="checkbox"/>	Hot flashes/night sweats
<input type="checkbox"/>	Abnormal PAP smear

Anything else you want your doctor to be aware of?