Medical Review of Systems

Click next to any symptom you have experienced recently, or for which you have concerns. Click again if you wish to remove the checkmark. Please print this form out after its complete and bring it with you to your appointment. If you don't understand something, write a question-mark by it on your print out. . Your doctor will discuss any positive responses with you.

Name: _____

Date: _____

General	
	Recent unexpected weight loss
	Chronic Fatigue
	Anemia
	Lack of regular exercise
	Overweight

Eyes	
	Failing Vision
	Eye pain
	Double Vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

Ears, Nose, Mouth	
	Decreased hearing
	Ringing in ear
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throats
	Prolonged hoarseness
	Tooth or jaw pain

Cardiovascular	
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

Pulmonary	
	Pneumonia / pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

Gastrointestinal	
	Recent loss of appetite
	Difficulty swallowing
	Heartburn/gastritis
	Persistent nausea/ vomiting
	Chronic abdominal pain
	Gall bladder trouble
	Jaundice (yellow skin)
	Change in appearance of stool
	Diarrhea
	Constipation
	Bloody or very black stools
	Hemorrhoids
	Hernia

Genito-Urinary	
	Frequent urine infections
	Blood in urine
	Kidney Stones
	Painful urination
	Loss of control of urine
	Decrease in flow
	Urination more than 2 times per night
	Any venereal disease in the past? (Herpes, Chlamydia, gonorrhea)

Musculoskeletal	
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

Integumentary	
	Skin rashes
	Hives
	Skin moles-black or changing
	Breast mass
	Nipple discharge

Neurologic	
	Frequent headaches
	Tremor/hands shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

Psychological	
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	No pleasure in life anymore

Endocrine	
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

Hematologic / Lymphatic	
	Excessive bruising or bleeding
	Swollen glands-neck, armpit or groin
	Unexplained fever, chills, night sweats

Allergic / Immunologic	
	Hay fever/Allergies
	Getting lots of infections
	Desire HIV discussion

Substance/Chemical Use	
	More than 6 drinks/week
	Use of tobacco products
	Caffeine use
	Over-the-counter medicine / vitamins

Anything else you want your doctor to be aware of?

Women Only	
	Periods Irregular
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear