

## Review of Systems

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

IS THE PATIENT CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

		Yes	No
CONSTITUTIONAL	Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>
EYES	Excessive Tearing	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	Edema (swelling)	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	Wheezing/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENT (SKIN)	Non-Healing Sores	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGIC	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL	Limitation of Motion	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGIC (HEME-LYMPH)	Easy Bruising/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

### HEALTH AND PREVENTATIVE SCREENING

#### HAVE YOU HAD ANY OF THE FOLLOWING?

PNEUMONIA VACCINE - EVER

YES  NO

INFLUENZA VACCINE -

YES  NO WHEN \_\_\_\_\_

	Right Ear	Both Ears	Left Ear
HEARING LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TINNITUS (NOISE IN EAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRESSURE/FULLNESS SENSATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR DRAINAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Check Social Behavior and Indicate how often, if former indicate former

	How much?	How Often?
TOBACCO - SMOKE OR CHEW		
ALCOHOL		

### Clinical USE Only

Review of Medications Completed

Completed by: \_\_\_\_\_