Name:_____DOB:_____Date:_____

Review of Systems Instructions: Answer yes if the following problems are **FREQUENT or BOTHERSOME.**

GENERAL:

Have you had a recent UNEXPLAINED change of weight 10+ pounds? YES / NO

Are you having any fevers? YES / NO

Are you experiencing EXCESSIVE fatigue? YES / NO

PULMONARY/LUNGS:

Are you short of breath? YES / NO

If Yes, are you short of breath ☐at rest or ☐with activity?

Do you have a bothersome cough that has been continuous for over 3 months? YES / NO

Do you wheeze? YES / NO

EARS, EYES, NOSE THROAT:

Have you noticed a change in your vision OTHER THAN needing new glasses? YES / No

When was your last eye exam?_____

CARDIOVASCULAR/ HEART:

Do you get chest pains? YES / NO

Do your legs swell? YES / NO

If Yes, do they swell at the end of the day and usually gone by morning? YES / NO

Do you have trouble breathing while lying in a flat position? YES / NO

Do you awaken at night gasping for air? YES / NO

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER, GALLBLADDER:

Do you have frequent nausea? YES / NO

Do you have frequent vomiting? YES / NO

Do you have diarrhea? YES / NO

Do you have bright red blood in your stools? YES / NO

Do you have black tar-like stools? YES / NO

Are you constipated? YES / NO

GENITOURINARY/GENITALS, KIDNEY, BLADDER, URINATION:

Do you have any burning or discomfort with urination? YES / NO

Do you urinate more frequently than normal? YES / NO

Do you urinate more than once or twice per night? YES / NO

Do you have any incontinence? YES / NO

If Yes, is it ☐Occasional ☐Frequent?

ENDOCRINE:

Do you have problems with excessive thirst? YES / NO

NEUROPSYCHIATRIC (NERVES, BRAIN)

Do you have numbness or tingling of your extremities? YES / NO

If yes, is this new? ☐Yes☐No If no have there been any changes? ☐Yes☐ No

Over the last **2 weeks** how often have you been bothered by any of the following problems?

Little Interest or Pleasure in doing things? ☐Not at all ☐ Several Days☐ More than Half the days☐Nearly every day

Feeling down, depressed or hopeless? ☐ Not at all ☐Several Days ☐More than Half the days☐Nearly every day

HEALTH MAINTENANCE (ADULTS ONLY):

What has your blood pressure been running? _____

Do you follow a low sodium diet? YES / NO

Do you exercise regularly? YES / NO

Do you follow a low cholesterol diet? YES / NO

DIABETICS ONLY:

What have your blood sugars been running in the morning? _____

Do you follow a diabetic diet? YES / NO