

REVIEW OF SYSTEMS
(PATIENT TO DOCUMENT PRIOR TO SEEING DOCTOR)

Have you had any new symptoms? Yes No
Do you have diabetes? Yes No

PATIENTS NAME: _____

GENERAL:

Weight loss? Yes No How much? _____
Decrease in energy? Yes No
Decrease in appetite? Yes No
Night sweats? Yes No
Fever? Yes No If so, how high? _____

SKIN:

Infections? Yes No
Ulcers? Yes No
Rashes? Yes No

Head, Eyes, Ears, Nose, Throat:

Sinus infection/pain? Yes No
Ear pain? Yes No
Change in hearing? Yes No
Eye pain? Yes No
Change in vision? Yes No
Nasal discharge? Yes No
Throat pain? Yes No

NEUROLOGICAL:

Headaches? Yes No
Troublesome or frequent headaches? Yes No
Recent change in vision? Yes No
Recent change in hearing? Yes No
Change in ability to feel things? Yes No
Painful sensations? Yes No
Decrease in muscle strength? Yes No
Decrease in ability to ambulate? Yes No

CARDIAC:

Chest pain? Yes No
Shortness of breath? Yes No
Fatigue? Yes No
Episodes of shortness of breath at night? Yes No
Decrease in ability to exert oneself? Yes No

PSYCHIATRIC:

Change in mood? Yes No
Change in behavior with family? Yes No
Change in ability to think? Yes No
Losing track of where one is, what time it is, or who one is? Yes No

RESPIRATORY:

Blood in sputum? Yes No
Cough or change in cough? Yes No
Shortness of breath when lying down? Yes No
Mucous production with cough? Yes No

HEMATOLOGIC:

Nosebleeds, rectal bleeding, or bleeding at other sites? (please specify) Yes No _____

EXTREMITIES:

Redness of a limb? Yes No
Swelling of a limb? Yes No
Discoloration of a limb? Yes No

GASTROINTESTINAL:

Difficulty swallowing food? Yes No
Pain with swallowing food? Yes No
Indigestion? Yes No
Nausea? Yes No
Vomiting? Yes No
Diarrhea? Yes No
Abdominal bloating? Yes No
Black stools? Yes No
Blood from the rectum? Yes No

TODAY'S MAIN COMPLAINT: _____

*****FOR OFFICE USE ONLY*****

GENITOURINARY:

Burning with urination? Yes No
Blood in urine? Yes No
Increase in need to urinate? Yes No
Increase in need to urinate at night? Yes No

HT _____ WT _____

BP _____ P _____ R _____ T _____

M.D. SIGNATURE: _____

DATE: _____

MUSCULOSKELETAL:

Arthritis? Yes No
Back pain? Yes No
New back pain? Yes No
Bone pain? Yes No
Muscle soreness? Yes No
Recent trauma or fractures? Yes No



Mark J. Adler, M.D. Daniel Vicario, M.D.
Rupa Subramanian, M.D. Lynette Cederquist, MD
Chris Lewis, PA-C