

NAME: _____ DATE: _____

REVIEW OF SYSTEMS

PLEASE CHECK EACH ANSWER:

		YES	NO	If "yes", please explain
1.) Constitutional:	Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.) Eyes:	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.) Ears, Nose, Mouth, Throat:	Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Mass	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.) Cardiovascular:	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.) Respiratory:	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Chronic Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Home Use of Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.) Gastrointestinal:	Bowel Habits/Change	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Crohns	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.) Hematologic / Lymphatic	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
	HIV+	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

(Please flip over for other side)

		YES	NO	If "yes", please explain
8.) Musculoskeletal:	Weakness/Numbness	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Joint Pain/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.) Integumentary (Skin/Breast):	Masses	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.) Neurologic:	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Severe Headaches/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
11.) Endocrine:	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
12.) Renal:	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Transplant	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Frequent Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
13.) Cancer	Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History: Single _____ Married _____ Divorced _____ Widowed _____

Occupation: _____

Do you smoke? Y N # _____ packs per day for _____ years
 Do you use alcohol? None / Socially / 2-3 times per week / with dinner
 Do you exercise? None / Occasionally / Weekly / Daily
 Do you drive? Y N

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

ROS & Social History Updated:

Year	Initials
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Physician Signature

Date

