

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: ____ / ____ / ____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:

- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (*around the eyes*)
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (*history of*)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (*runny nose*)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (*ringing in the ears*)
- TMJ Disorder

Cardiovascular:

- None
- Angina (*chest pain or discomfort*)
- Chest Pain
- Claudication (*leg pain or achiness*)
- Heart Murmur
- Heart Problems
- Orthopnea (*difficulty breathing while lying*)
- Palpitations (*irregular or forceful heart beat*)
- Paroxysmal Nocturnal Dyspnea (*shortness of breath at night*)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

Gastrointestinal:

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (*yellowing of the skin*)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (*quality*)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:

- None
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (*numbness, prickling, or tingling*)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:

- None
- Anaphylaxis (*history of*)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:

- None
- Anhedonia (*inability to experience joy or enjoy life*)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

Female:

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above-named patient:

Provider Signature

Date