

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle YES or NO
PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED

Constitutional Symptoms Fever YES NO Chills YES NO Headache YES NO Other _____	Integumentary Skin rash YES NO Boils YES NO Persistent itch YES NO Other _____
Eyes Blurred vision YES NO Double vision YES NO Pain YES NO Other _____	Musculoskeletal Joint pain YES NO Neck pain YES NO Back pain YES NO Other _____
Allergic / Immunologic Hay fever YES NO Drug allergies YES NO Other _____	Ear / Nose / Throat / Mouth Ear infection YES NO Sore throat YES NO Sinus problems YES NO Other _____
Neurological Tremors YES NO Dizzy spells YES NO Numbness / tingling YES NO Other _____	Genitourinary Urine retention YES NO Painful urination YES NO Urinary frequency YES NO Other _____
Endocrine Excessive thirst YES NO Too hot / cold YES NO Tired / sluggish YES NO Other _____	Respiratory Wheezing YES NO Frequent cough YES NO Shortness of breath YES NO Other _____
Gastrointestinal Abdominal pain YES NO Nausea / vomiting YES NO Indigestion / heartburn YES NO Other _____	Hematological / Lymphatic Swollen glands YES NO Blood clotting problems YES NO Other _____
Cardiovascular Chest pain YES NO Varicose veins YES NO High blood pressure YES NO Other _____	Psychologic Are you generally satisfied with your life? YES NO Do you feel severely depressed? YES NO Have you considered suicide? YES NO Other _____

Physician use only: (Comments / Notes)

	<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th># Answer</th> <th>Level of Service</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">0 – 1</td> <td style="text-align: center;">1 or 2</td> </tr> <tr> <td style="text-align: center;">2 - 9</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">10+</td> <td style="text-align: center;">4 or 5</td> </tr> </tbody> </table>	# Answer	Level of Service	0 – 1	1 or 2	2 - 9	3	10+	4 or 5
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Physician: _____ **Date:** / /