# Review of Systems

If you suffer from any of the following health problems, place a check in the space provided.

| General | Check if "yes" | Additional Details |
|---|---|---|
| Weight loss | | |
| Weight gain | | |
| Fever | | |
| Chills | | |
| **Eyes** | | |
| Blurred Vision | | |
| Itchy Eyes | | |
| **ENT** | | |
| Dizziness | | |
| Nose Bleeds | | |
| Voice Change | | |
| Hearing Loss | | |
| **GI** | | |
| Nausea or Vomiting | | |
| Diarrhea | | |
| Blood in Stool | | |
| **Heart** | | |
| Chest Pain | | |
| Racing Heart Rate | | |
| Leg Swelling | | |
| **Lungs** | | |
| Shortness of Breath | | |
| New Cough | | |
| Wheezing | | |
| **Endocrine** | | |
| Frequent urination | | |
| **Neuro** | | |
| Loss of memory | | |
| Numbness | | |
| Involuntary Movement | | |
| **Skin** | | |
| Rashes | | |
| Itching | | |
| Changes in Moles | | |
| **Psych** | | |
| Depressed Mood | | |
| Sleep Disturbance | | |
| Crying Spells | | |
| Anxiety | | |
| **MS** | | |
| Joint Pain | | |
| Stiffness | | |
| **GU** | | |
| Pain with urination | | |
| Incontinence | | |
| Weak Urine Stream | | |
| None of the above | | |

| Problems | Check if yes | Additional Details |
|---|---|---|
| None of the Below | | |
| ADHD | | |
| AIDS/HIV | | |
| Allergies: seasonal or food | | |
| Anemia | | |
| Anorexia or Bulimia | | |
| Anxiety Disorder | | |
| Arthritis | | |
| Asthma | | |
| Birth Defects or Inherited Disease | | |
| Bladder or prostate problems | | |
| Blood Diseases, or blood type | | |
| Broken bones or fracture | | |
| COPD/Emphysema | | |
| Cancer | | |
| Chicken Pox (age) | | |
| Colitis/Crohns or Irritable Bowel | | |
| Constipation | | |
| Depression | | |
| Developmental or Behavioral Disorders | | |
| Diabetes | | |
| Diverticulosis | | |
| Ear or Hearing Problems | | |
| Fibromyalgia | | |
| Gallbladder disease | | |
| Gastrointestinal Problems | | |
| Gout | | |
| Head Injury/Concussion | | |

| | | |
|---|---|---|
| Headaches | | |
| Heart Disease | | |
| Heart murmur | | |
| Hepatitis A, B, or C | | |
| High Cholesterol | | |
| High blood pressure/Hypertension | | |
| Hospital admission other than birth | | |
| Hypo or hyperthyroid | | |
| Kidney disease or stones | | |
| Liver Disease | | |
| Mental Illness | | |
| Muscle, Joint, or Bone Problems | | |
| Osteoporosis | | |
| Pulmonary Embolism | | |
| Reflux/GERD | | |
| Seizures/Epilepsy | | |
| Sexual dysfunction | | |
| Skin Problems | | |
| Stroke | | |
| Tuberculosis | | |
| Varicose veins | | |
| Vision or Eye Problems | | |

SOCIAL HISTORY

Name: _____ Date: _____

**PLEASE CIRCLE THE CORRECT ANSWER AND FILL IN THE BLANKS.**

1. Do you smoke now? Yes or No
   Did you ever smoke for more than 1 month? Yes or No
   Year Started: _____ Quit Year: _____
2. Did you graduate from high school, college, graduate school?
   (Please circle all that apply)
3. What is your occupation? _____
   Who is your employer? _____
4. Number of children? _____
5. Do you use marijuana? Yes or No
   Do you use any street drugs? Yes or No
   Have you ever used a needle to inject street drugs? Yes or No
6. Do you consider yourself heterosexual/bisexual/homosexual?
7. Do you currently chew tobacco? Yes or No
8. Has your Mother, Father, Sister or Brother had a heart attack or stroke before the age of 60?
   Yes or No
9. Are you Married, Single, Divorced, Widowed, Domestic Partner, Separated?
   _____
10. Do you have a loaded gun in your home that is not locked up? Yes or No
11. How many days per week do you exercise? If so, how long?
    _____
12. How many alcoholic beverages do you drink each week?
    _____
13. Are you right, left or ambidextrous handed?
    _____
14. In a month's time, how many days do you drink more than 5 alcoholic beverages?
    _____
15. Is your mother alive? Yes or No
    a. In which year was she born? 19_ _.
16. Is your father alive? Yes or No
    a. In which year was he born? 19_ _.