

PATIENT REVIEW OF SYSTEMS

Please check the “**current**” box for all conditions that you are now experiencing and mark the “**ever**” box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked “**Doctor’s Notes Only**”.

	Current	Ever	Doctor’s Notes Only Please do not write in this space.
GENERAL	↙	↙	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	
Chills	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	
Change in routine	<input type="checkbox"/>	<input type="checkbox"/>	
HEAD			
Headache	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>	
EYES			
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>	
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	
EARS			
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	
Drainage	<input type="checkbox"/>	<input type="checkbox"/>	
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	
NOSE			
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH			
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
NECK			
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	

	Current	Ever	Doctor’s Notes Only Please do not write in this space.
LUNGS	↙	↙	
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
VASCULAR			
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Cold feet or hands	<input type="checkbox"/>	<input type="checkbox"/>	
Discolored foot/hand	<input type="checkbox"/>	<input type="checkbox"/>	
Hot feet or hands	<input type="checkbox"/>	<input type="checkbox"/>	
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
G-I SYSTEM			
Gas	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
G-U SYSTEM			
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	
Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>	
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	
Genital infection	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	

Please turn the page over and complete the checklist on the reverse side before handing this page to your intern.

PATIENT REVIEW OF SYSTEMS

Please check the “**current**” box for all conditions that you are now experiencing and mark the “**ever**” box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked “**Doctor’s Notes Only**”.

	Current	Ever	Doctor’s Notes Only Please do not write in this space.
PSYCHOLOGIC	↓	↓	
Excessive Stress	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	
SKIN			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	
Warts	<input type="checkbox"/>	<input type="checkbox"/>	
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>	
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Peeling	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGIC			
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	
Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
MUSCLE/BONE			
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
Bone pain	<input type="checkbox"/>	<input type="checkbox"/>	
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	
CONDITIONS			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer / Tumor	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson’s	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	

	Current	Ever	Doctor’s Notes Only Please do not write in this space.
MEDICATION	↓	↓	
Please bring a list of prescription medications.			
Please bring a list of non prescribed medications.			
Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational drug	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL			
Surgery-any area	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Prior prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL			
Consume alcohol			
Consume coffee			
Consume tea			
Consume sodas			
Smoker			
Aerobic exercise			
Sleep			
Please bring a list of vitamins taken.			
Herbs	<input type="checkbox"/>	<input type="checkbox"/>	
Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	
Water intake/day	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
OB GYN			
Age period began			
Last Breast exam			
Last PAP date			
Pregnancy-present			
Pregnancy-past			
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
PMS	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	

Intern Name (Print) _____ Initial _____

Clinician Signature _____ Date _____

Patient Name _____ File # _____