Initial Review of Systems

Patients Name: (print) ______________________ Today's Date: ___/___/___

Reason for visit: ______________________

Constitutional Symptoms

Good general health lately ☐ No ☐ Yes
Recent weight change ☐ No ☐ Yes
Fever Fatigue ☐ No ☐ Yes
Headaches ☐ No ☐ Yes

Cardiovascular

Heart trouble/murmurs ☐ No ☐ Yes
Chest pain or angina pectoris ☐ No ☐ Yes
High Blood pressure ☐ No ☐ Yes

Neurological

Frequent or recurring headaches ☐ No ☐ Yes
Light headed or dizzy ☐ No ☐ Yes
Convulsions or seizures ☐ No ☐ Yes
Numbness or tingling sensations ☐ No ☐ Yes
Tremors ☐ No ☐ Yes
Paralysis ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
Head Injury ☐ No ☐ Yes

Respiratory

Chronic or frequent coughs ☐ No ☐ Yes
Spitting up blood ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Asthma or wheezing ☐ No ☐ Yes
Chronic Lung Condition

Glandular or hormone problem ☐ No ☐ Yes
Thyroid disease ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
Do you take Glucophage? ☐ No ☐ Yes
Excessive thirst or urination ☐ No ☐ Yes