Review of Systems Questionnaire
Metro West Center For Well Being

Patient name_____
Date of Birth_____
Date of appointment_____
PCP_____

History of Allergies

Latex allergy? Yes or No_____
Environmental Allergies? Yes or No _____
Medication Allergies? Yes or No _____

Please identify any concerns in the following categories that pertain to you and provide further info in the comments below.

General:

_ Weakness
_ Fatigue
_ Fever/sore throat
_ Frequent headache
_ Body aches
_ Swollen glands (neck/underarms)
_ Hair loss
_ Dizziness
_ Change in weight or appetite
_ Change in sleep pattern

Comments:_____
_____
_____

Eyes:

Date of last eye exam_____

_ Glasses/Contacts?
_ Vision changes
_ Color blindness
_ Night blindness
_ Pink eye (conjunctivitis)
_ Excessive tearing or discharge
_ Double vision/eye crossing
_ Eye pain/tiredness

Comments:_____
_____
_____

Endocrine:

_ Excessively hot/cold
_ Excessive thirst/hunger
_ Slow healing of injuries
_ History of Diabetes or Thyroid problems

Comments:_____
_____
_____

Ears, Nose, Throat:

_ Change in hearing
_ Ringing
_ Drainage
_ Speech problem
_ Post-nasal drip
_ Hoarseness
_ Difficulty swallowing
_ Frequent Nosebleeds
_ Bleeding gums
_ Sinus/facial pain

Comments:_____
_____
_____

Cardiovascular:

_ Palpitations (heart pounding)
_ Irregular heartbeat
_ Fatigue/Fainting with exercise
_ Waking at night with shortness of breath
_ Ankle swelling
_ known heart/rhythm problems
_ Chest pain/angina

Comments:_____
_____
_____

Respiratory:

Positive TB test?

_____

_ Recurrent cough
_ Night sweats
_ Coughing blood
_ Wheezing (or other asthma symptoms)
_ Shortness of breath (with/without exertion)

Comments:_____
_____
_____

Gastro-Intestinal:

_ Vomiting
_ Stomach/Abdominal Pain
_ Indigestion/frequent heartburn
_ Constipation/diarrhea
_ Blood in stool/black stool
_ History of jaundice

Comments:_____
_____
_____

Genito-Urinary:

_ Painful urination
_ Frequent urination
_ Blood in urine
_ History of urinary tract infections?
_ History of kidney stones

Comments:_____
_____
_____

Musculoskeletal:

_ pain/stiffness in joints
_ muscle weakness
_ twitching/deformity in extremities
_ Chronic back pain
_ History of Fracture

Comments:_____
_____
_____

Sexual History/ Female:

Sexually Active? Yes or No. If yes, at what age? _____ Date of last period_____
Age of first period _____ Method of Contraception, if applicable_____
Do you have regular cycles?_____ Are you pregnant now?_____
Have you ever been pregnant?_____ If yes, any problems? _____
Date of last Pap smear (if over 21)_____

_ Vaginal burning/itching
_ Vaginal discharge
_ History of STDs
_ Miscarriage(s)
_ Abortion(s)

Comments:_____
_____
_____

Sexual History/Male:

Sexually active? Yes or No If yes, at what age? _____ Contraception?
_____

_ Discharge from penis?
_ History of STDs

_ Pain or lump in testicles? _ Unilateral or Bilateral breast enlargement

Comments:_____
_____
_____

Nervous System:

_ Numbness or tingling sensations _ Head injury/concussion
_ dizziness or loss of balance _ Seizures
_ Gaps in memory

Comments:_____
_____
_____

Skin:

_ Itching/rash _ other skin concerns
_ Change in warts/moles or birthmarks

Comments:_____
_____
_____

Heme/Lymph:

_ Easily bruised _ Bone pain
_ Frequent infections _ History of anemia/thalassemia

Comments:_____
_____
_____

Breasts:

_ Pain/lump/discomfort _ Itchy/cracked/sore nipple
_ Discharge (watery/milky/pus) _ Other changes/abnormalities

Comments:_____
_____
_____

Psychiatric:

_ ADHD _ Difficulty sleeping
_ Nervousness/anxiety/stress _ Nightmares

_ Depression/Mania
_ Panic attacks
_ Rape/partner violence or harassment
_ Other psychiatric concerns

Comments:_____
_____
_____

Substance Use:

_ Smoker (how much?)
_ Illegal drug use
_ Prescription drug issues
_ Alcohol use (how much/often?)

Comments:_____
_____
_____