REVIEW OF SYSTEMS QUESTIONAIRE
PATIENT'S NAME: DATE:

PATIENT'S AGE: _____

PARENT/GUARDIAN: _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL : [ ] Tiredness or Fatigue [ ]Fever [ ]Weight Gain >10 pounds
[ ] Weight Loss >10 pounds [ ] Trouble sleeping [ ] Fever [ ] Night sweats

HEENT : [ ] Vision Problems [ ] Eye Pain [ ] Eye Redness
[ ]Hearing Problems [ ] Earache [ ] Nose Bleeds [ ] Sinus Problems
[ ] Dry Mouth [ ] Hoarseness [ ] Sore Throat [ ] Neck Pain
[ ] Swollen Glands

RESPIRATORY : [ ] Cough [ ] Wheezing/Asthma [ ] Decreased Exercise Tolerance

CARDIOVASCULAR: [ ] Chest Pain [ ] Shortness of breath
[ ] Palpitations/Irregular Heart Beat [ ] Heart Murmurs
[ ] Family members with serious heart trouble
[ ] Family members with high cholesterol

GASTROINTESTINAL: [ ] Trouble Swallowing [ ] Heartburn [ ] Nausea
[ ] Vomiting [ ] Abdominal Pain [ ] Diarrhea [ ] Constipation [
] Blood in stools

GENITOURINARY (FEMALE): Age of first Menstrual Period ___
[ ] Sexually Active [ ] Irregular Periods [ ] Menstrual Cramps
[ ] Vaginal Discharge [ ] Difficulty Urinating [ ] Blood in Urine
[ ] Frequent Urination [ ] Painful Urination

GENITOURINARY (MALE): [ ] Difficulty Urinating [ ] Blood in Urine
[ ] Frequent Urination [ ] Painful Urination [ ] Sexually Active
[ ] Trouble getting or maintaining erection [ ]Testicular Pain
[ ] Testicular Lumps

MUSCULOSKELETAL: [ ] Joint Pain [ ] Joint Redness [ ]Joint Swelling
[ ] Joint Stiffness [ ] Muscle Weakness [ ]Muscle Aches/Pains
[ ] Muscle Stiffness

SKIN: [ ] Nail Changes [ ] Sores [ ] Rash [ ] Itching [ ] Skin Color Changes

BREAST : [ ]Breast Lumps [ ] Breast Pain [ ] Nipple Discharge
[ ] Skin Changes

REVIEW OF SYSTEMS QUESTIONAIRE
PATIENT'S NAME: DATE:

NEUROLOGICAL : [ ] Headaches [ ] Migraines [ ] Dizziness [ ] Head Injury
[ ] Seizures [ ] Numbness/Tingling [ ] Tremors or Shakes
[ ] Tics or Twitches

PSYCHIATRIC : [ ] Sadness [ ] Depression [ ] Anxiety
[ ] Change in Sleep Pattern [ ] Hearing voices or seeing visions
[ ] Suicidal Thoughts [ ] Behavior Problems

ENDOCRINE : [ ]Appetite Changes [ ] Cold Intolerance
[ ] Increased Thirst [ ] Increased Urination [ ] Hair Changes

HEMATOLOGY: [ ] Easy Bruising [ ] Easy Bleeding [ ] History of Anemia
[ ] Enlarged Lymph Nodes

ALLERGIC/IMMUNOLOGIC: [ ] Seasonal Runny Nose/congestion
[ ] Frequent Infections [ ] Allergic Reactions

ARE YOU ALLERGIC TO ANY MEDICATIONS? [ ] No [ ] Yes

If yes, please list medication name and type of reaction:

Do you smoke cigarettes? [ ] No [ ] Yes

If yes, how many and how often?

PLEASE GIVE THIS FORM TO DR. LANDIS AT YOUR APPOINTMENT