

REVIEW OF SYSTEMS

Primary Care Physician: _____

Chief Complaint: _____

Location of Complaint: _____

On a scale of 1 to 10, with 10 being the worst, how does your discomfort rate: _____

When did symptoms begin: _____

What makes the problem better: _____

What makes the problem worse: _____

How long does discomfort last: _____

Is anything else occurring at the same time: _____

Is the problem constant or variable: _____

Does the problem interfere with your daily functions: _____

Are you on a special diet: _____

Do you or have you had any problems related to any of the following symptoms:

Circle yes.

- | | | | |
|----------------|-------------------------|-----------------|-------------------------|
| Fever | Tremors | Diarrhea | Urinary Tract Infection |
| Chills | Blood Clotting Problems | Chest Pain | Frequent Cough |
| Weight Loss | Dizzy Spells | Skin Rash | Shortness of Breath |
| Fatigue | Numbness/Tingling | Boils | Swollen Glands |
| Blurred Vision | Excessive Thirst | Persistent Itch | Wheezing |
| Double Vision | Too Hot/Too Cold | Joint Pain | Nausea/Vomiting |
| Ear Infections | Tired/Sluggish | Neck Pain | Hay Fever |
| Sore Throat | Blood in Stool | Back Pain | Sinus Problems |
| Abdominal Pain | Urinary Retention | | |

PATIENT NAME: _____ DATE: _____