

REHABILITATION MEDICINE ASSOCIATES, P.C.

REVIEW OF SYSTEMS Name: _____ Date: _____

(Please Print)

Please review the following symptoms and check the appropriate box if the symptom is **Absent** or **Present** at the time you complete the form. Please give a brief explanation of any symptoms that you indicate are currently present.

Symptoms		Explanation
Absent	Present	CONSTITUTIONAL
<input type="checkbox"/>	<input type="checkbox"/>	Weight change
<input type="checkbox"/>	<input type="checkbox"/>	Appetite change
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Back pain at night
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Excessive tiredness
<input type="checkbox"/>	<input type="checkbox"/>	Generalized morning stiffness
<input type="checkbox"/>	<input type="checkbox"/>	___Anxious; ___ Irritable; ___Angry
<input type="checkbox"/>	<input type="checkbox"/>	Poor attention / concentration
<input type="checkbox"/>	<input type="checkbox"/>	Unusual stress: ___ at home; ___ at work
Absent	Present	EYES / ENT
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes / Red eyes
<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
Absent	Present	RESPIRATORY (Breathing)
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough
<input type="checkbox"/>	<input type="checkbox"/>	Cough up blood
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath: ___at rest; ___with activity; ___when lying flat
<input type="checkbox"/>	<input type="checkbox"/>	Pain in chest with deep breath
Absent	Present	CARDIOVASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain / chest tightness: ___at rest; ___with activity
<input type="checkbox"/>	<input type="checkbox"/>	Swelling (edema) in legs / feet
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat (pulse) / palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
Absent	Present	GU / BLADDER / URINARY
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urination
<input type="checkbox"/>	<input type="checkbox"/>	___ Slow stream; ___ Dribbling after urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination: ___ daytime; ___ night
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Pain / burning with urination
<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction
Absent	Present	GI / BOWEL
<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits: ___constipation; ___diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Black stools
<input type="checkbox"/>	<input type="checkbox"/>	Red blood in stools
<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain
<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting

Absent	Present	SKIN / LYMPHATIC
<input type="checkbox"/>	<input type="checkbox"/>	Skin breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Changes in mole
<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Lumps: ___neck; ___arm pit; ___groin
<input type="checkbox"/>	<input type="checkbox"/>	Hair pattern changes
Absent	Present	ORTHOPEDIC / MUSCULOSKELETAL
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain / swelling / instability / loss of motion (list joints):
<input type="checkbox"/>	<input type="checkbox"/>	Foot problems
Absent	Present	NEUROLOGIC
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	<input type="checkbox"/>	Decreased smell / taste
<input type="checkbox"/>	<input type="checkbox"/>	Vision problems: ___double vision; ___blurred vision; ___loss of vision
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems: ___hearing loss; ___ringing
<input type="checkbox"/>	<input type="checkbox"/>	Swallowing problems / choking
<input type="checkbox"/>	<input type="checkbox"/>	Arm / Leg weakness
<input type="checkbox"/>	<input type="checkbox"/>	Arm / Leg numbness, tingling, pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain: ___back; ___neck; ___arm; ___leg
<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Light headedness / Vertigo
<input type="checkbox"/>	<input type="checkbox"/>	Impaired Balance
<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control
<input type="checkbox"/>	<input type="checkbox"/>	Loss of bowel control
<input type="checkbox"/>	<input type="checkbox"/>	Loss of sensation in genital / rectal area
Absent	Present	WOMEN'S HEALTH
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Vaginal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Currently Painful Menstrual Periods
<input type="checkbox"/>	<input type="checkbox"/>	Increased Back Pain with Menstrual Periods
<input type="checkbox"/>	<input type="checkbox"/>	Pap Smear Within the Last Two (2) Years
<input type="checkbox"/>	<input type="checkbox"/>	Perform Monthly Breast Self-Exam
<input type="checkbox"/>	<input type="checkbox"/>	Other Menstrual Problems, Explain:
		OTHER

Patient's Signature: _____ Date: _____

MD/DO Reviewed: _____ Date: _____