

Adult Review Of Systems

Name: _____ Date of Birth: _____ Date: _____

Please check (✓) the statements that apply to you.

- I am worried about my overall health.
- I have lost or gained weight in the last 6 months.
- I have questions about my regular diet or eating habits.
- I smoke.
- I drink more than 2 alcoholic beverages daily.
- I am excessively tired.
- I drink more than 5 cups of coffee or tea (not decaffeinated) daily.
- I have difficulty sleeping.
- I don't get much exercise.
- I have developed new allergies.
- I have problems with my eyes, ears, vision or hearing.
- I have frequent headaches.
- I am bothered by dizziness or fainting.
- I have problems with rashes, itching or bruising.
- I have a lump or mole that concerns me.
- I have frequent colds, sore throats or nasal stuffiness.
- I have chest pain.
- I have a cough, blood in my sputum, nighttime sweating.
- I have a problem with my lungs.
- I have times when my heart beats very fast or notice palpitations.
- I get out of breath easily.
- I have a problem with my heart.
- I have or have had high blood pressure.
- I have leg cramps or ankle swelling.
- There is a change in my bowel habits.
- I am bothered by stomach pain, nausea, vomiting or severe gas.
- I have problems with constipation or diarrhea.
- I have a problem with rectal bleeding or black stools.
- I urinate less than I think I should.
- I urinate more than I think I should, especially at night.
- I have a discharge that concerns me.
- I have a question about birth control.
- I have joint, leg, arm or back pain; unusual stiffness or swelling.
- I have numbness in my hands and feet.
- I am too hot or too cold.
- There has been a death or serious illness of a family member this year.
- I am unhappy, worried, or discouraged.
- I don't enjoy my job.
- I am concerned about my sex life.

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- I am worried about my marriage.
- I have family problems.
- I have too much stress in general.
- I am easily angered.
- I can't relax.
- I cry a lot.
- I am concerned about my personal safety at home or at the work site.
- I wish to talk to the doctor or nurse practitioner about a confidential matter.
- There are problems that this questionnaire has not addressed.
- I am currently seeing other physicians or psychologists, etc.
- My last tetanus shot was more than 10 years ago.

Regarding Alcohol:

- Have you ever considered cutting down?
- Has your drinking annoyed others?
- Has your drinking ever caused you to feel guilty?
- Have you ever needed an eye opener (drink) in the morning?

Please list any serious illness and/or hospitalizations you have had since your last physical.

Please list all medications that you are taking at the present time, including vitamins, herbal or homeopathic preparations.

Thank You.