NAME:_____ TODAY'S DATE:_____

Piedmont Family Practice

Review of Systems: Please indicate if you have had any of these problems on a **recurrent** or **chronic** basis in the past 2 years

GENERAL	Yes	No
General good health	☐	☐
Recent weight change	☐	☐
Change in activity level	☐	☐
Change in appetite	☐	☐
Fevers/chills	☐	☐
Night sweats	☐	☐
Unexplained fatigue	☐	☐

EYES		
Last eye exam_____		
Redness	☐	☐
Itching	☐	☐
Watery	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐
Contacts/glasses	☐	☐

EARS		
Pain	☐	☐
Feel plugged up	☐	☐
Decreased hearing	☐	☐
Ringing	☐	☐

NOSE		
Freq. Bloody nose	☐	☐
Frequent sneezing	☐	☐
Chronic or Seasonal:		
Post nasal drip	☐	☐
Nasal congestion	☐	☐

THROAT		
Freq. soreness	☐	☐
Difficulty swallowing	☐	☐
Freq. hoarseness	☐	☐
Mouth sores	☐	☐
Bleeding gums	☐	☐
Bad breath	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Wheezing	☐	☐
Shortness of breath:		
At rest	☐	☐
With exertion	☐	☐
Coughing up:		
Blood	☐	☐
Sputum/phlegm	☐	☐

CARDIOVASCULAR		
Palpitations	☐	☐
Fainting	☐	☐
Chest pain/pressure	☐	☐
Swelling of hands/feet	☐	☐
Trouble breathing:	☐	☐
At night	☐	☐
# pillows used_____		

HEMATOLOGIC		
Easy bruising	☐	☐
Excessive bleeding	☐	☐
Enlarged lymph nodes	☐	☐

ENDOCRINE		
(changes in):		
Tolerance to heat/cold	☐	☐
Thirst or urination	☐	☐
Skin dryness	☐	☐
Hair loss	☐	☐

SKIN		
Rashes	☐	☐
Generalized itching	☐	☐
Change in growth/mole	☐	☐
New growth/mole	☐	☐

GASTROINTEST	Yes	No
Abdominal Pain	☐	☐
Loss of appetite	☐	☐
Heartburn/indigestion	☐	☐
Nausea/vomiting	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bowel movements:		
Change in	☐	☐
Blood	☐	☐
Pain during	☐	☐
Difficulty controlling	☐	☐

GENITOURINARY		
Freq. urination	☐	☐
Painful urination	☐	☐
Urgency w/urination	☐	☐
Difficulty starting urine	☐	☐
Leaking urine	☐	☐
Change in urine system	☐	☐
Urinating at night	☐	☐
Sexual problems	☐	☐
Male:		
Impotence	☐	☐
Testicle pain/lump	☐	☐
Female:		
Pain with periods	☐	☐
Irregular periods	☐	☐
Vaginal discharge	☐	☐
Vaginal dryness	☐	☐
Pain w/intercourse	☐	☐
Vaginal bleeding		
after menopause	☐	☐
Abnormal PAPs	☐	☐
Last PAP_____		
Last menstrual period_____		

BREAST	Yes	No
Pain	☐	☐
Lumps	☐	☐
Nipple discharge	☐	☐
Month self exam	☐	☐
Abnorm. mamm.	☐	☐
Last mammogram_____		

NEUROLOGICAL		
Freq. headaches	☐	☐
Lighthead/dizzy	☐	☐
Seizures	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Sensitive to light	☐	☐
Memory loss	☐	☐
Gen. weakness	☐	☐

MUSCULOSKELETAL		
Joint pain	☐	☐
Joint stiffness	☐	☐
Joint swelling	☐	☐
Muscle pain	☐	☐
Muscle weakness	☐	☐
Back pain	☐	☐
Difficult walking	☐	☐

PSYCHIATRIC		
Mood swings	☐	☐
Nervous/anxious	☐	☐
Depression	☐	☐
Insomnia	☐	☐
Crying easily	☐	☐
Lack motivation	☐	☐
Lack concentration	☐	☐
Feeling sad	☐	☐