

REVIEW OF SYSTEMS

PATIENT _____

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?
CIRCLE YES OR NO AND PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.

GENITOURINARY

RETENTION OR URINE	Y	N
PAIN OR BURNING WITH URINATION	Y	N
URGENT URINATION	Y	N
FREQUENT URINATION	Y	N
LOSS OF URINE CONTROL	Y	N
BLOOD IN THE URINE	Y	N
URINARY TRACT INFECTION	Y	N

OTHER: _____

CONSTITUTIONAL SYMPTOMS

FEVER	Y	N
CHILLS	Y	N
HEADACHE	Y	N

OTHER: _____

SKIN

RASH	Y	N
BOILS	Y	N
PERSISTENT ITCHING	Y	N

OTHER: _____

ALLERGY / IMMUNOLOGY

HAY FEVER	Y	N
DRUG ALLERGIES	Y	N

OTHER: _____

GASTROINTESTINAL

ABDOMINAL PAIN	Y	N
NAUSEA/VOMITING	Y	N
ULCERS	Y	N
INDIGESTION/HEARTBURN	Y	N

OTHER: _____

EAR / NOSE / THROAT / MOUTH

EAR INFECTION	Y	N
SORE THROAT	Y	N
SINUS PROBLEMS	Y	N

OTHER: _____

RESPIRATORY

WHEEZING	Y	N
FREQUENT COUGH	Y	N
SHORTNESS OF BREATH	Y	N

OTHER: _____

CARDIOVASCULAR

CHEST PAIN	Y	N
HEART ATTACK	Y	N
HEART MURMUR	Y	N
MITRAL VALVE PROLAPSE	Y	N
ANTIBIOTICS BEFORE DENTIST VISIT	Y	N
IRREGULAR BEAT OR PALPITATIONS	Y	N
STROKE	Y	N
HIGH BLOOD PRESSURE	Y	N

OTHER: _____

EYES

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
GLAUCOMA	Y	N

OTHER: _____

MUSCULOSKELETAL

JOINT PAIN	Y	N
NECK PAIN	Y	N
BACK PAIN	Y	N

OTHER: _____

NEUROLOGICAL

TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMBNESS OR TINGLING	Y	N

OTHER: _____

ENDOCRINE

EXCESSIVE THIRST	Y	N
TOO HOT OR COLD	Y	N
THYROID	Y	N
DIABETES	Y	N
TIRED OR SLUGGISH	Y	N

OTHER: _____

HEMATOLOGY / LYMPHATIC

SWOLLEN GLANDS	Y	N
BLOOD CLOTTING PROBLEMS	Y	N
CANCER	Y	N

OTHER: _____

PLEASE COMPLETE IF YOU ARE A MALE OVER 40 YEARS OF AGE

OVER THE PAST MONTH OR SO, HOW OFTEN HAVE YOU ...

	NOT AT ALL	LESS THAN 1 IN 5	LESS THAN HALF	HALF THE TIME	MORE THAN HALF	ALL THE TIME
HAD A SENSATION OF NOT EMPTYING YOUR BLADDER COMPLETELY?	0	1	2	3	4	5
HAD TO URINATE LESS THAN TWO HOURS AFTER YOU FINISHED URINATING?	0	1	2	3	4	5
STOPPED AND STARTED SEVERAL TIMES WHEN YOU URINATED?	0	1	2	3	4	5
FOUND IT DIFFICULT TO POSTPONE URINATION?	0	1	2	3	4	5
HAD A WEAK STREAM?	0	1	2	3	4	5
HAD TO PUSH OR STRAIN TO BEGIN URINATION?	0	1	2	3	4	5
HOW MANY TIMES <i>PER</i> NIGHT HAVE YOU GOTTEN UP TO URINATE FROM THE TIME YOU WENT TO BED TO THE TIME YOU GOT UP?	0	1	2	3	4	5+

REVIEWED BY: _____ DATE: _____