Adult Review of Systems

Name: _____ Date of Birth: _____ Date: _____

Please check the statements that apply to you.

- ❑ I am worried about my overall health.
- ❑ My parents had diabetes, thyroid problems, heart problems, or stroke at my age. (Circle all that apply)
- ❑ I have lost or gained weight in the last 6 months.
- ❑ 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 have developed new allergies.
- ❑ I have problems with my eyes, ears, vision, or hearing. (Circle all that apply)
- ❑ 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 or times when my heart beats very fast or I notice palpitations.
- ❑ I have a problem with my heart.
- ❑ I have or have had high blood pressure.
- ❑ I have a cough, blood in my sputum, nighttime sweating.
- ❑ I have a problem with my lungs.
- ❑ I get out of breath easily.
- ❑ 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 a problem with rectal bleeding or black stools.
- ❑ I urinate less or more than I think I should. (Circle which one applies)
- ❑ I have vaginal bleeding or spotting.
- ❑ 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.
- ❑ I am worried about my marriage.
- ❑ I have family problems.
- ❑ I have too much stress in general.
- ❑ I am easily angered, can't relax, or cry a lot. (Circle all that apply)
- ❑ I am concerned about my personal safety at home or at the work site.
- ❑ I am currently seeing other physicians or psychologists, etc.
- ❑ My last tetanus shot was more than 10 years ago.
- ❑ My last flu shot was more than 1 year ago.
- ❑ I have not had a breast exam in the last year.
- ❑ **Date of last mammogram: _____ Where done:_____**
- ❑ I have not had a pelvic exam in the last year.
- ❑ **Date of last pap smear: _____ Where done: _____**
- ❑ I have not had a rectal exam in the last year.
- ❑ **Date of last colonoscopy: _____ Name of provider: _____**
- ❑ **Date of last eye exam: _____ Name of eye doctor: _____**
- ❑ **Date of last dental exam: _____ Name of dentist: _____**

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 need an eye opener (drink) in the morning?

- ❑ I wish to talk to the doctor or nurse practitioner about a confidential matter.
- ❑ There are problems that this questionnaire has not addressed. Please list.

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