Senior Review of Systems

Name:_____Date of Birth:_____Date_____

Please check (√) the Statements that apply to you.

- ❑ I am worried about my overall health.
- ❑ My mobility has declined.
- ❑ I have fallen at times.
- ❑ I have lost or gained weight in the last 6 months.
- ❑ I have a decrease in my appetite.
- ❑ I take over the counter medications.
- ❑ I smoke.
- ❑ I drink more than 2 alcoholic beverages daily.
- ❑ I am excessively tired.
- ❑ I don't have "get up and go" anymore.
- ❑ I drink more than 5 cups of coffee, tea, or soda (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 a lot of earwax.
- ❑ 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 of diarrhea.
- ❑ I have a problem with rectal bleeding or black stools.

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- I urinate less that I think I should.
- I urinate more than I think I should, especially at night.
- I sometimes lose control of my bladder.
- I have a discharge that concerns me.
- 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 feel depressed sometimes.
- I am concerned about my sex life.
- I have not seen a dentist in the last year.
- I have not seen an optometrist in the last year.
- I do not have/know about advanced directives.
- I have few social supports.
- I am worried about caring for my spouse.
- I have few family supports.
- 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.
- My last flu shot was more than 1 year ago.
- I have not had a pneumovax.
- I have not been evaluated for osteoporosis.
- I have not had a breast exam in the last year.
- I have not had a pelvic exam in the last year.
- I have not had a rectal exam in the last year.
- My parents had sugar diabetes when they were my age.
- My parents had thyroid problems at my age.
- My parents had heart or stroke problems at my age.

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Regarding alcohol:

- Have you ever considering 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.

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

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Thank You.