# Horizon Family Medical Group

Review of Systems

Name__________________________ Date___________

Do you now or have you had any problems related to the following systems? **Please circle yes or no.**

**Constitutional Symptoms**
- Fever ……………….. Y N
- Chills……………….……Y N
- Headache…………….…..Y N
- Unexplained Wt. Loss...Y N
- Wt. Gain………………Y N
- Problems sleeping...…...Y N
- Other_________________________________

**Endocrine**
- Excessive thirst………Y N
- Too hot / cold..……….Y N
- Tired / sluggish……….Y N
- Other_________________________________

**Eyes**
- Blurred vision ………...Y N
- Double vision ………...Y N
- Eye pain ………………Y N
- Other_________________________________

**Ear/Nose/Throat**
- Ear infection…………Y N
- Hearing loss…………..Y N
- Sore throat……………Y N
- Sinus problems……….Y N
- Other_________________________________

**Cardiovascular**
- Chest pain……………..…Y N
- Varicose veins………...Y N
- High blood pressure…..Y N
- Fainting spells……..…..Y N
- Leg cramps when walking…..Y N
- Other_________________________________

**Respiratory**
- Shortness of breath……Y N
- Wheezing…..…………Y N
- Frequent cough………..Y N
- Other__________________________________

**Gastrointestinal**
- Abdominal pain…………..……Y N
- Nausea/vomiting…………....Y N
- Indigestion/heartburn……….Y N
- Change in bowel habits……..Y N
- Rectal bleeding/black stools...Y N
- Other_________________________________

**Genitourinary / Gyn**
- Urinary frequency………..…..Y N
- Painful urination…………..…Y N
- Incontinence………………...Y N
- Blood in urine…………..…...Y N
- Impotence…………………...Y N
- Pelvic pain…………………..…Y N
- Abnormal vaginal bleeding….Y N
- Abnormal discharge…………Y N
- #of pregnancies_____ #of live births_____
- Other_________________________________

**Musculoskeletal / Neurological**
- Joint pain / swelling………..Y N
- Neck pain……….………..Y N
- Back pain…………………..…..Y N
- Seizures……………………..Y N
- Numbness…………………..…..Y N
- Other__________________________________

**Hematologic**
- Swollen glands…………….Y N
- Blood clotting problems…...Y N
- Other__________________________________

**Allergic / Immunologic/ Skin**
- Rash………………………..Y N
- Itching……………………...Y N
- Hay fever…………………..Y N
- Other__________________________________

**Psychologic**
- Do you feel depressed……...Y N
- Have you feel anxious/panic Y N
- Other__________________________________

**Clinician's comments:**

**Clinician's initials /date of review**

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