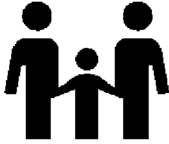

Foley Family Practice

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Adult Review of Systems (pg 1)

Confidential Record: Information contained will not be released unless you authorize us to do so.

Name: ______________________ ________________________________ _______
Last First MI

Date of Birth: ____/ ____/ ______

Review Of Systems: Please check **ONLY** those symptoms you have had **FREQUENTLY** in the past **3 MONTHS**.

Constitutional:	Eyes:
☐ Fever ☐ Night Sweats ☐ Weight gain (_____lbs.) ☐ Weight loss (_____lbs.) ☐ Exercise intolerance ☐ Chills ☐ Feeling tired or poorly ☐ None of the above ☐ Notes:___________________________	☐ Dry eyes ☐ Irritation ☐ Vision change ☐ Blurred vision ☐ Difficulty seeing at night ☐ Seeing double images (diplopia) ☐ Wavy lines in vision ☐ Gritty eyes ☐ Itching ☐ Pain in eyes ☐ None of the above ☐ Notes:________________________
Ears, Nose, Mouth, Throat ENMT: Ears: ☐ Ear pain ☐ None of the above ☐ Notes:________________________ Nose: ☐ Frequent nosebleeds ☐ Nose / Sinus problems ☐ None of the above ☐ Notes:________________________ Mouth / Throat: ☐ Sore throat ☐ Bleeding gums ☐ Snoring ☐ Dry Mouth ☐ Oral abnormalities ☐ Mouth ulcer	Cardiovascular: ☐ Chest pain on exertion ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Shortness of breath when lying down ☐ Palpitations ☐ Known heart murmur ☐ Light-headed on standing ☐ None of the above ☐ Notes:________________________

Adult Review of Systems (pg 2)

Mouth / Throat continued:

- ☐ Teeth abnormalities
- ☐ Mouth breathing
- ☐ Hoarseness
- ☐ Choking
- ☐ Weak Voice
- ☐ None of the above
- ☐ Notes:______________________________

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Sleep apnea
- ☐ None of the above
- ☐ Notes:_____________________________

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Change in appetite
- ☐ Black or tarry stools
- ☐ Frequent Diarrhea
- ☐ Vomiting blood
- ☐ Nausea
- ☐ "Coffee Grounds" material in stool
- ☐ Heartburn
- ☐ Constipation
- ☐ Bright red blood per rectum
- ☐ A change in the stool
- ☐ None of the above
- ☐ Notes:____________________________

Genitourinary:

- ☐ Urinary loss of control
- ☐ Difficulty urinating
- ☐ Increased urinary frequency
- ☐ Hematuria – blood in urine
- ☐ Incomplete emptying
- ☐ Pain in the flank
- ☐ Dysuria - pain during urination
- ☐ 4 or more UTIs in the last 6 months

Changes in urinary habits:

- ☐ Urinary frequency - _____ times during the day
- ☐ Urinary frequency - _____ times during the night
- ☐ Initiating urination requires standing
- ☐ Smaller urine stream
  - O Dribbling at end
  - O Post – void dribbling
- ☐ Starts and stops
- ☐ Feelings of urgency
- ☐ Delays in starting (hesitancy)

Musculoskeletal:

- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Arthralgias / joint pain
- ☐ Back pain
- ☐ Swelling in the extremities
- ☐ None of the above
- ☐ Notes:____________________________

Adult Review of Systems (pg 3)

<table>
<tr>
<td>Genitourinary continued:
Males:
☐ Blood in semen
☐ Penile discharge
☐ Curvature with erection
☐ Scrotal lump
☐ Scrotal pain
Females:
☐ Vaginal discharge
☐ None of the above
☐ Notes:______________________________</td>
<td></td>
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<tr>
<td>Integumentary (Skin):
☐ Abnormal mole
☐ Jaundice
☐ Rash
☐ Itching
☐ Dry skin
☐ Growths / lesions
☐ None of the above
☐ Notes:_____________________________</td>
<td>Neurologic:
☐ Loss of consciousness
☐ Weakness
☐ Numbness
☐ Seizures
☐ Dizziness
☐ Frequent or severe headaches
☐ Migraines
☐ Restless legs
☐ None of the above
☐ Notes:____________________________</td>
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Adult Review of Systems (pg 4)

Psychiatric:

- ☐ Depression
- ☐ Sleep disturbances
- ☐ Restless Sleep
- ☐ Feeling unsafe in relationship
- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Nervous
- ☐ Loss of pleasure
- ☐ Loss of interest in activities
- ☐ Apathy – Feeling that nothing matters
- ☐ Feeling demoralized
- ☐ Anhedonia – Loss of pleasure from usual activities
- ☐ Homicidal thoughts
- ☐ No desire to continue living
  - O with suicide plan
  - O stated intent of suicide
  - O wish to be dead
  - O thinking about suicide
- ☐ Emotional lability
- ☐ Grieving
- ☐ Hypersensitivity
- ☐ Loneliness
- ☐ Depression accompanied by:
  - O eating more
  - O decreased functioning ability
  - O feeling more tired in morning than
  - O sexual behavior
  - O decreased need for sleep
- ☐ None of the above
- ☐ Notes:______________________________

Endocrine:

- ☐ Fatigue
- ☐ Increased thirst
- ☐ Hair loss
- ☐ increased hair growth
- ☐ cold intolerance
- ☐ excessive sweating
- ☐ None of the above
- ☐ Notes:______________________________

Hematologic / Lymphatic:

- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ None of the above
- ☐ Notes:______________________________

Allergic / Immunologic:

- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing
- ☐ None of the above
- ☐ Notes:______________________________

____ ____/ ____/ ______

Patient Signature Date