

Patient Data Sheet

Name: _____

Review of Systems

Please check for symptoms you have frequently.

Head: Headaches? _____
 Light-headedness? _____
 Dizziness (vertigo)? _____
 Epilepsy/seizures? _____

Circulation: Ankle swelling? _____
 Varicose veins? _____
 Numbness? _____

Eyes: Glasses? _____
 Blurring of vision? _____
 Pain in your eyes? _____
 Discharge from eyes? _____
 Spot or ragged lines? _____

Gastrointestinal: Heartburn? _____
 Trouble swallowing? _____
 Bloody or black stools? _____
 Hemorrhoids? _____
 Constipation? _____
 Vomiting or nausea? _____
 Diarrhea? _____
 Abdominal pain? _____
 Stomach/duodenal ulcer? _____
 Burping or reflux? _____

ENT: Ringing in ear? _____
 Hearing loss? _____
 Motion sickness? _____
 Hoarseness? _____
 Postnasal drip? _____
 Dental problems? _____
 Nose bleeds? _____
 Sinus/facial pain? _____

For Men only: Pain or lump in testes? _____
 Difficulty with erection? _____
 Slow stream of urination? _____
 Sexually transmitted illness? _____

Chest: Frequent cough? _____
 Cough up blood? _____
 Pleurisy? _____
 Wheezing? _____
 Palpitation? _____
 Chest pain? _____
 Shortness of breath? _____

For Women only: Last menstrual period? _____
 Date of last mammogram _____
 Date of last Pap smear _____
 Number of pregnancies _____
 Number of live births _____
 Age menstruation began _____
 Pain with intercourse? _____
 Bleeding between periods? _____
 Sexually transmitted illness? _____
 Perform self breast exam? _____
 Vaginal itching or discharge? _____
 Complications of pregnancy? _____
 Abnormal Pap smear in past? _____

Kidneys: Kidney stones? _____
 Infections? _____
 Burning on urination? _____
 Blood in urine? _____
 Frequency? _____

Skin: Changing moles? _____
 Acne? _____
 Rash? _____
 Itching? _____