Adult Review of Systems
(All adult patients at time of annual physical exam)

General/Constitutional
- ☐ Unexplained weight loss of gain
- ☐ Excessive fatigue
- ☐ Prolonged fever/chills
- ☐ Other: _____

Head/Eyes/Ears/Nose/Throat
- ☐ Frequent or severe headaches
- ☐ Wears glasses or contact lenses
- ☐ Chronic nasal discharge, drainage or sneezing
- ☐ Impaired hearing
- ☐ Date of last eye exam _____
- ☐ Date of last dental exam _____
- ☐ Other: _____

Neurological
- ☐ Memory loss
- ☐ Fainting, dizziness, seizures, convulsions
- ☐ Other: _____

Cardiovascular
- ☐ Rheumatic fever
- ☐ Pain or pressure in chest/Angina
- ☐ Heart trouble
- ☐ Palpitations or pounding heart
- ☐ Abnormal heart rhythm or murmur
- ☐ Swelling of the ankles
- ☐ High blood pressure
- ☐ Other: _____

Respiratory
- ☐ Chronic cough
- ☐ Asthma or wheezing
- ☐ Shortness of breath at night
- ☐ Shortness of breath
- ☐ Other: _____

Gastrointestinal
- ☐ Abdominal pain
- ☐ Loss of appetite
- ☐ Change in bowl habits (constipation or diarrhea)
- ☐ Noted blood in stool
- ☐ Hemorrhoids or rectal disease
- ☐ Date of last Colonoscopy: _____
- ☐ Other: _____

Genitourinary
- ☐ Frequent urination at night
- ☐ Frequent painful urination
- ☐ Difficulty stopping or starting urine stream
- ☐ Urinary tract infection
- ☐ Other: _____

Musculoskeletal
- ☐ Pain in joints/arthritis
- ☐ Chronic back pain or injury
- ☐ Other: _____

Emotional
- ☐ Trouble sleeping
- ☐ Feeling depressed
- ☐ Anxious or nervous
- ☐ Loss of memory
- ☐ Other: _____

Skin/Breast
- ☐ Change or new growth in mole
- ☐ Breast lump
- ☐ Breast nipple discharge
- ☐ Other: _____

Hematological/Lymph
- ☐ Anemia
- ☐ Excessive bleeding or abnormal bruising
- ☐ A transfusion
- ☐ Any swelling of lymph nodes
- ☐ Other: _____

Sexual

No. of partners in the past year _____
Form of birth control _____
- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual

Female
- ☐ Mid cycle bleeding
- ☐ Pain with intercourse
- ☐ Vaginal discharge or sores
- ☐ Painful periods
- ☐ Sexually transmitted disease
- ☐ Problem with sexual function
- ☐ Irregular periods

Last menstrual period _____ No. of live births _____
Last pap smear _____ No. of pregnancies_____
Abnormal pap smear? **Yes No**
Date of last Mammogram _____
Date of last Bone Density Exam _____

Male
- ☐ Sores of discharge from penis
- ☐ Lump on or pain of testicle
- ☐ Sexually transmitted disease
- ☐ Condom use
- ☐ Problems with sexual function

Patient's Name _____ **Date of Birth** _____