

Evan D. O'Brien, M.D., P.C.

Review of Systems

Name: _____ Date: _____

Have you been experiencing any of the following symptoms and/or conditions in the last 6 months?

| | | YES | NO | | | YES | NO |
|-------------|-----------------------|--------------------------|--------------------------|------------------|----------------------|--------------------------|--------------------------|
| General | | | | Cardiovascular | | | |
| | Weight Change | <input type="checkbox"/> | <input type="checkbox"/> | | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | | Murmurs | <input type="checkbox"/> | <input type="checkbox"/> |
| | Fever | <input type="checkbox"/> | <input type="checkbox"/> | | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| | Sweats | <input type="checkbox"/> | <input type="checkbox"/> | | Palpitations | <input type="checkbox"/> | <input type="checkbox"/> |
| | Chills | <input type="checkbox"/> | <input type="checkbox"/> | | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes | | | | | Edema | <input type="checkbox"/> | <input type="checkbox"/> |
| | Change in Vision | <input type="checkbox"/> | <input type="checkbox"/> | | Leg Cramps | <input type="checkbox"/> | <input type="checkbox"/> |
| | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | Previous Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> |
| | Redness | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal | | | |
| | Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | | Trouble Swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| | Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> |
| | Spots | <input type="checkbox"/> | <input type="checkbox"/> | | Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | | Indigestion | <input type="checkbox"/> | <input type="checkbox"/> |
| Ent | | | | | Rectal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| | Change in Hearing | <input type="checkbox"/> | <input type="checkbox"/> | | Black/Tarry Stools | <input type="checkbox"/> | <input type="checkbox"/> |
| | Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> | | Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| | Vertigo | <input type="checkbox"/> | <input type="checkbox"/> | | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| | Earaches | <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary | | | |
| | Infections | <input type="checkbox"/> | <input type="checkbox"/> | | Increased Urination | <input type="checkbox"/> | <input type="checkbox"/> |
| | Discharge | <input type="checkbox"/> | <input type="checkbox"/> | | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> |
| | Frequent Colds | <input type="checkbox"/> | <input type="checkbox"/> | | Difficulty Urinating | <input type="checkbox"/> | <input type="checkbox"/> |
| | Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> |
| | Frequent Sore Throats | <input type="checkbox"/> | <input type="checkbox"/> | | Urgency | <input type="checkbox"/> | <input type="checkbox"/> |
| | Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | | Incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin/breast | | | | Musculoskeletal | | | |
| | Rashes | <input type="checkbox"/> | <input type="checkbox"/> | | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| | Lumps | <input type="checkbox"/> | <input type="checkbox"/> | | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| | Itching | <input type="checkbox"/> | <input type="checkbox"/> | | Stiffness | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dry Skin | <input type="checkbox"/> | <input type="checkbox"/> | | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| | Color Change | <input type="checkbox"/> | <input type="checkbox"/> | | Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | | | | | Backache | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cough | <input type="checkbox"/> | <input type="checkbox"/> | Neurological | | | |
| | Sputum | <input type="checkbox"/> | <input type="checkbox"/> | | Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| | Coughing Blood | <input type="checkbox"/> | <input type="checkbox"/> | | Blackouts | <input type="checkbox"/> | <input type="checkbox"/> |
| | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | | Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | | Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | | Tingling | <input type="checkbox"/> | <input type="checkbox"/> |
| | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | | Tremors | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |

| Psychiatric | | YES | NO | Hematologic | | YES | NO |
|-------------|--------------------|--------------------------|--------------------------|-------------|-----------------------------|--------------------------|--------------------------|
| | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| | Tension | <input type="checkbox"/> | <input type="checkbox"/> | | Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| | Depression | <input type="checkbox"/> | <input type="checkbox"/> | | Easy Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| | Memory Trouble | <input type="checkbox"/> | <input type="checkbox"/> | | Previous Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine | | | | Allergic | | | |
| | Thyroid Trouble | <input type="checkbox"/> | <input type="checkbox"/> | | Please List All Allergies: | | |
| | Heat Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | | 1. _____ | | |
| | Cold Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | | 2. _____ | | |
| | Excessive Sweating | <input type="checkbox"/> | <input type="checkbox"/> | | 3. _____ | | |
| | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Family Physician: _____ Tel _____ Fax: _____

Cardiologist: _____ Tel _____ Fax: _____

Other Physician: _____ Tel _____ Fax: _____

Attorney: _____ Tel _____ Fax: _____

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Initially Reviewed Date: _____

Comments on positive responses:

Physician/Practitioner Signature: _____