

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"/>
	Ringling 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: _____