Health MOMENTUM CENTRE FOR THERAPEUTIC MEDICINE

REVIEW OF SYSTEMS

Name:
Date:

Y = A condition you have **now**
P = A condition you have had in the **past**

GENERAL

Weight ________
Height ________

Recent weight change	❑Y	❑P
Fatigue/Weakness	❑Y	❑P

SKIN

Rashes	❑Y	❑P
Eczema, hives	❑Y	❑P
Acne, boils	❑Y	❑P
Itching	❑Y	❑P
Colour change	❑Y	❑P
Lumps	❑Y	❑P
Night sweats	❑Y	❑P
Dryness/moistness	❑Y	❑P
Temperature changes	❑Y	❑P
Nail changes	❑Y	❑P
Changes in mole	❑Y	❑P
Skin cancer	❑Y	❑P

HEAD

Headache	❑Y	❑P
Head injury	❑Y	❑P
Dizziness	❑Y	❑P
Changes in hair texture/quantity	❑Y	❑P

EYES

Impaired vision	❑Y	❑P
Eye pain	❑Y	❑P
Tearing/dryness	❑Y	❑P
Double vision	❑Y	❑P
Glaucoma	❑Y	❑P
Cataracts	❑Y	❑P
Blurring	❑Y	❑P
Itching	❑Y	❑P
Redness	❑Y	❑P
Discharge	❑Y	❑P
Blind spot	❑Y	❑P

EARS

Impaired hearing	❑Y	❑P
Earache	❑Y	❑P
Dizziness	❑Y	❑P
Discharge	❑Y	❑P
Infections	❑Y	❑P
Ringing	❑Y	❑P

NOSE/SINUSES

Frequent colds	❑Y	❑P
Nose bleeds	❑Y	❑P
Stuffiness	❑Y	❑P
Hay fever	❑Y	❑P
Sinus problems	❑Y	❑P
Post-nasal drip	❑Y	❑P

MOUTH/THROAT

Frequent sore throat	❑Y	❑P
Sore tongue/mouth	❑Y	❑P
Gum problems	❑Y	❑P
Hoarseness	❑Y	❑P
Dental cavities	❑Y	❑P
Loss of taste	❑Y	❑P

NECK

Lumps	❑Y	❑P
Swollen glands	❑Y	❑P
Goitre	❑Y	❑P
Pain/stiffness	❑Y	❑P

RESPIRATORY

Cough	❑Y	❑P

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Sputum ❑Y ❑P
Spitting up blood ❑Y ❑P
Wheezing ❑Y ❑P

Asthma ❑Y ❑P
Bronchitis ❑Y ❑P
Pneumonia ❑Y ❑P
Emphysema ❑Y ❑P
Difficulty breathing ❑Y ❑P
Pain on breathing ❑Y ❑P
Shortness of breath ❑Y ❑P
Tuberculosis ❑Y ❑P
Tuberculin Test ❑Y ❑P
Last Chest X-Ray _____________

BREASTS

Do you do self exams ❑Y ❑P
Lumps ❑Y ❑P
Pain/tenderness ❑Y ❑P
Nipple discharge ❑Y ❑P

GASTROINTESTINAL

Trouble swallowing ❑Y ❑P
Heartburn ❑Y ❑P
Change in thirst ❑Y ❑P
Change in appetite ❑Y ❑P
Nausea/Vomiting ❑Y ❑P
Vomiting blood ❑Y ❑P
Blood in stool ❑Y ❑P
Belching/Flatulence ❑Y ❑P
Jaundice (yellow skin) ❑Y ❑P
Liver disease ❑Y ❑P
Gall bladder disease ❑Y ❑P
Ulcer ❑Y ❑P
Indigestion ❑Y ❑P
Diarrhea ❑Y ❑P
Constipation (less than 1 stool/day) ❑Y ❑P
Rectal bleeding ❑Y ❑P
Haemorrhoids ❑Y ❑P
Black, tarry stool ❑Y ❑P
Abdominal pain ❑Y ❑P
Food allergy ❑Y ❑P
Hernias ❑Y ❑P

CARDIOVASCULAR

High blood pressure ❑Y ❑P
Rheumatic fever ❑Y ❑P
Swollen ankles ❑Y ❑P
Chest pain ❑Y ❑P
Palpitations ❑Y ❑P
High cholesterol ❑Y ❑P
Heart murmurs ❑Y ❑P

URINARY

Pain on urination ❑Y ❑P
Increased frequency ❑Y ❑P
Frequency at night ❑Y ❑P
Inability to hold urine ❑Y ❑P
Frequent infections ❑Y ❑P
Kidney stones ❑Y ❑P
Blood in urine ❑Y ❑P
Urgency ❑Y ❑P
Hesitancy ❑Y ❑P

MALE REPRODUCTIVE

Hernias ❑Y ❑P
Testicular masses ❑Y ❑P
Testicular pain ❑Y ❑P
Sexual difficulties ❑Y ❑P
STD ❑Y ❑P
Discharge/sores ❑Y ❑P
Date of last prostate exam _______

FEMALE REPRODUCTIVE

Age menses began _____________
Average number of days ________
Length of cycle _______________
Last menstrual period __________
Last PAP test (date) ____________
Number of pregnancies _________
Number of miscarriages ________
Number of abortions ___________
Are you sexually active ❑Y ❑P
Currently pregnant ❑Y ❑P
Bleeding between periods ❑Y ❑P
Are cycles regular ❑Y ❑P
Pain during intercourse ❑Y ❑P
Painful menses ❑Y ❑P
Excessive flow ❑Y ❑P
PMS ❑Y ❑P

Birth control (and type)	❑Y	❑P
Difficulty conceiving	❑Y	❑P
Sexual difficulties	❑Y	❑P
STD	❑Y	❑P
Vaginal discharge	❑Y	❑P
Vaginal itching/dryness	❑Y	❑P

MUSCULOSKELETAL

Joint pain/stiffness	❑Y	❑P
Arthritis/gout	❑Y	❑P
Broken bones	❑Y	❑P
Muscle spasms/cramps	❑Y	❑P
Joint swelling	❑Y	❑P
Backache	❑Y	❑P

PERIPHERAL VASCULAR

Deep leg pain	❑Y	❑P
Cold hands/feet	❑Y	❑P
Varicose veins	❑Y	❑P
Leg cramps	❑Y	❑P
Extremity numbness	❑Y	❑P
Extremity swelling	❑Y	❑P
Extremity ulcers	❑Y	❑P

NEUROLOGIC

Fainting	❑Y	❑P
Seizures/convulsions	❑Y	❑P
Paralysis	❑Y	❑P
Muscle weakness	❑Y	❑P
Numbness/tingling	❑Y	❑P
Loss of memory	❑Y	❑P
Involuntary movement	❑Y	❑P
Loss of balance	❑Y	❑P
Speech problems	❑Y	❑P

ENDOCRINE

Heat/cold intolerance	❑Y	❑P
Thyroid trouble	❑Y	❑P
Excessive thirst/hunger	❑Y	❑P
Excessive urination	❑Y	❑P
Excessive sweating	❑Y	❑P
Diabetes	❑Y	❑P
Low blood sugar	❑Y	❑P
Hormone therapy	❑Y	❑P

BLOOD/LYMPHATIC

Anemia	❑Y	❑P
Easy bleeding/bruising	❑Y	❑P
Past transfusions	❑Y	❑P
Lymph node swelling	❑Y	❑P

EMOTIONAL

Depression	❑Y	❑P
Mood swings	❑Y	❑P
Anxiety/nervousness	❑Y	❑P
Tension	❑Y	❑P
Phobias	❑Y	❑P
Alcohol/drug use	❑Y	❑P
Insomnia	❑Y	❑P

HOBBIES/HABITS

Do you eat 3 meals per day?	❑Y	❑N
Do you wake well rested?	❑Y	❑N
Do you sleep well?	❑Y	❑N
Do you average 6-8 hours sleep?	❑Y	❑N
Do you enjoy your work?	❑Y	❑N
Do you watch television?	❑Y	❑N
Do you read?	❑Y	❑N
Do you exercise?	❑Y	❑N
How many hours/day? ________		
Do you take vacations?	❑Y	❑N