4. Review of Systems (ROS)

Cardiovascular-Circulatory-Hematological

Heart Disease ____Y ____N _____P
Heart Murmurs ____Y ____N _____P
Chest Pain ____Y ____N _____P
Palpitations ____Y ____N _____P
Rheumatic Fever ____Y ____N _____P
High/Low Blood Pressure ____Y ____N _____P
Stroke ____Y ____N _____P
Swelling of Ankles ____Y ____N _____P
Varicose Veins ____Y ____N _____P
Thrombophlebitis ____Y ____N _____P
Easy Bleeding ____Y ____N _____P
Easy Bruising ____Y ____N _____P
Anemia ____Y ____N _____P
Other____________________________________

Musculoskeletal

Pain ____Y ____N _____P
Muscle Spasms ____Y ____N _____P
Arthritis ____Y ____N _____P
Arm Pain ____Y ____N _____P
Upper Back Pain ____Y ____N _____P
Mid-back Pain ____Y ____N _____P
Lower Back Pain ____Y ____N _____P
Leg Pain ____Y ____N _____P
Joint Pain ____Y ____N _____P
Other____________________________________

Head

Headaches ____Y ____N _____P
Migraines ____Y ____N _____P
Teeth Grinding ____Y ____N _____P
TMJ/Jaw Problems ____Y ____N _____P
Head Injury ____Y ____N _____P
Other____________________________________

Respiratory

Pleurisy ____Y ____N _____P
Asthma ____Y ____N _____P
Emphysema ____Y ____N _____P
Tuberculosis ____Y ____N _____P
Persistent ____Y ____N _____P
Cough ____Y ____N _____P
Difficulty Breathing ____Y ____N _____P
Frequent Colds ____Y ____N _____P
Shortness of Breath ____Y ____N _____P
Sleep Apnea ____Y ____N _____P
Tuberculosis ____Y ____N _____P
Other____________________________________

Neurological

Dizziness ____Y ____N _____P
Loss of Balance ____Y ____N _____P
Paralysis ____Y ____N _____P
Muscle Weakness ____Y ____N _____P
Atrophy ____Y ____N _____P
Numbness ____Y ____N _____P
Tingling ____Y ____N _____P
Seizures ____Y ____N _____P
Epilepsy ____Y ____N _____P
Memory Loss ____Y ____N _____P
Insomnia ____Y ____N _____P
Somnolence ____Y ____N _____P
Other____________________________________

Neck

Lumps ____Y ____N _____P
Goiter ____Y ____N _____P
Swollen Glands ____Y ____N _____P
Neck Pain ____Y ____N _____P
Whiplash ____Y ____N _____P
Other____________________________________

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Gastrointestinal

Ulcers ____Y ____N _____P
Changes in Appetite ____Y ____N _____P
Nausea / Vomiting ____Y ____N _____P
Epigastric Pain ____Y ____N _____P
Passing Gas ____Y ____N _____P
Heartburn ____Y ____N _____P
Belching ____Y ____N _____P
Gall Bladder Disease ____Y ____N _____P
Liver Disease ____Y ____N _____P
Hepatitis B or C ____Y ____N _____P
Abdominal Pain ____Y ____N _____P
Hemorrhoids ____Y ____N _____P
Blood in Stool ____Y ____N _____P
Undigested Food ____Y ____N _____P
Diarrhea ____Y ____N _____P
Constipation ____Y ____N _____P
Mucus ____Y ____N _____P
Other___________________________________

Nose, Ear, Throat, Mouth

Sinus Problems ____Y ____N _____P
Hay Fever ____Y ____N _____P
Stuffy Nose ____Y ____N _____P
Loss of Smell ____Y ____N _____P
Nose Bleeds ____Y ____N _____P
Impaired Hearing ____Y ____N _____P
Ear Ringing ____Y ____N _____P
Earaches ____Y ____N _____P
Dry Throat ____Y ____N _____P
Sore Throat ____Y ____N _____P
Chapped Lips ____Y ____N _____P
Mouth Fissures ____Y ____N _____P
Other___________________________________

Endocrine

Hypothyroid ____Y ____N _____P
Hyperthyroid ____Y ____N _____P
Hypoglycemia ____Y ____N _____P
Diabetes ____Y ____N _____P
Excessive Thirst ____Y ____N _____P
Excessive Hunger ____Y ____N _____P
Night Sweats ____Y ____N _____P
Feelings of Hot or Cold ____Y ____N _____P
Fatigue ____Y ____N _____P
Other___________________________________

Integumentary

Rashes ____Y ____N _____P
Acne, Boils ____Y ____N _____P
Skin Color Change ____Y ____N _____P
Lumps ____Y ____N _____P
Eczema ____Y ____N _____P
Hives ____Y ____N _____P
Psoriasis ____Y ____N _____P
Itching ____Y ____N _____P
Hair Loss ____Y ____N _____P
Brittle Nails ____Y ____N _____P
Other___________________________________

Genitourinary

Kidney Disease ____Y ____N _____P
Painful Urination ____Y ____N _____P
Difficult Urination ____Y ____N _____P
Frequent Urination ____Y ____N _____P
Urination at Night ____Y ____N _____P
Kidney Stones ____Y ____N _____P
Blood in Urine ____Y ____N _____P
Urinary Tract Infections ____Y ____N _____P
Venereal Disease ____Y ____N _____P
Other___________________________________

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Female Reproductive

Age of first menses? ______________________

Age of menopause? ________________________

Length of cycle? _________________________

Duration of menses? ______________________

Irregular Cycles	____Y	____N	_____P
PMS?	____Y	____N	_____P
Heavy Flow	____Y	____N	_____P
Spotting	____Y	____N	_____P
Clotting	____Y	____N	_____P
Menopausal Symptoms	____Y	____N	_____P
Vaginal Discharge	____Y	____N	_____P
Date of last exam/PAP?	_________________		
Endometriosis	____Y	____N	_____P
Ovarian Cysts	____Y	____N	_____P
Breast Lumps	____Y	____N	_____P
Breast Tenderness	____Y	____N	_____P
Nipple Discharge	____Y	____N	_____P
Sexual Orientation?	__________________		
Sexually active?	____Y	____N	_____P
Irregular Libido?	_____High	_____Low	
Pain with intercourse	____Y	____N	_____P
Vaginal Dryness	____Y	____N	_____P
Cervical Dysplasia	____Y	____N	_____P
Genital Warts	____Y	____N	_____P
Chlamydia	____Y	____N	_____P
Gonorrhea	____Y	____N	_____P
Herpes	____Y	____N	_____P
Syphilis	____Y	____N	_____P
Birth Control	____Y	____N	_____P

What type? _____________________________

Number of pregnancies? __________________

Number of live births? ___________________

Number of miscarriages? _________________

Number of abortions? ____________________

Difficulty Conceiving	____Y	____N	_____P

Other__________________________________

Male Reproductive

Hernia	____Y	____N	_____P
Sexual Orientation	_________________		
Sexually Active	____Y	____N	_____P
Sexual Difficulties	____Y	____N	_____P
Irregular Libido?	_____High	_____Low	
Impotence	____Y	____N	_____P
Premature Ejaculation	____Y	____N	_____P
Penile Discharge	____Y	____N	_____P
Genital Warts	____Y	____N	_____P
Chlamydia	____Y	____N	_____P
Gonorrhea	____Y	____N	_____P
Syphilis	____Y	____N	_____P
Herpes	____Y	____N	_____P
Prostrate Problems	____Y	____N	_____P
Testicular Pain	____Y	____N	_____P
Testicular Swelling	____Y	____N	_____P

Other__________________________________

Mental, Emotional

Mood Swings	____Y	____N	_____P
Depression	____Y	____N	_____P
Nervousness	____Y	____N	_____P
Bi-polar	____Y	____N	_____P
Psychosis	____Y	____N	_____P
Neurosis	____Y	____N	_____P
ADHD	____Y	____N	_____P
Hallucinations	____Y	____N	_____P
Suicidal Tendencies	____Y	____N	_____P
Mental Tension	____Y	____N	_____P
Seasonal Depression	____Y	____N	_____P

Other__________________________________

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Eyes

Impaired Vision	____Y	____N	_____P
Night Blindness	____Y	____N	_____P
Double Vision	____Y	____N	_____P
Blurriness	____Y	____N	_____P
Spots in Eyes	____Y	____N	_____P
Eye Pain/Strain	____Y	____N	_____P
Glaucoma	____Y	____N	_____P
Cataracts	____Y	____N	_____P
Glasses/Contacts	____Y	____N	_____P
Tearing Eyes	____Y	____N	_____P
Dry Eyes	____Y	____N	_____P

Other

Immune

Chronic Fatigue	____Y	____N	_____P
Low-grade Fever	____Y	____N	_____P
Chronic Infections	____Y	____N	_____P
Slow Wound Healing	____Y	____N	_____P

Other___________________________________

Immunizations

Tetanus	____Y	____N
Diphtheria	____Y	____N
Polio	____Y	____N
Measles/ Mumps/ Rubella	____Y	____N

Other___________________________________

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