



Patient Name: _____
Social Security Number: _____
Date: _____

Review Of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Dose	Date Taken

Do you have any known allergies:

Do you currently smoke?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Do you have or have you had any of the following conditions:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Vision Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Hearing Loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Ear Infections (Other Than Childhood)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Sinus Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Repeated Nosebleeds
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Long Term Sore Throat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Pneumonia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Asthma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Close Contact With Person(s) With Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Tuberculosis Vaccine (BCC)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Positive Tuberculosis Skin Test
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Cough

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Shortness of Breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Lung Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heart Murmur
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Mitral Valve Prolapse
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Heart Valve Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heart Attack
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heart Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Chest Pains
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Fainting
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Irregular Heart Beat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Heart Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	High Blood Pressure in Pregnancy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	High Blood Pressure, Other
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Raynaud's Disease, Raynaud's Phenomenon
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Poor Blood Circulation
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Severe Nausea And Vomiting in Pregnancy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Severe Nausea And Vomiting Before Pregnancy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Intestinal Problems (Irritable Colon, Chron's Disease, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Dietary Restrictions
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Recurring Diarrhea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Constipation Problem
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heartburn, Reflux
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Hepatitis, Yellow Jaundice
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Liver Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Bladder or Kidney Infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Kidney Stones
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Problems With Urine
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Menstrual Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Infertility, Difficulty Getting Pregnant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Vaginal Infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Herpes Or A Partner With Herpes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Sexually Transmitted Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Pelvic Inflammatory Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Gonorrhea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Chlamydia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Syphilis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Genital Warts
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	HIV Infection, AIDS Or A Partner With HIV / AIDS
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Abnormal Pap Smears

