Entire Family Clinics

Review of Systems (ROS)

(Please complete the form by checking the boxes that you have current concerns about.)

Today's Date: _____

Patient Name: _____ DOB: _____

Constitutional	☐ Fever ☐ Significant weight change ☐ Significant appetite change	**Urology**	☐ Frequent urination ☐ Urinary incontinence ☐ Pain with urination ☐ Blood in urine ☐ Urinary urgency
Eye	☐ Vision problems ☐ Eye irritation ☐ Eye pain	**Musculoskeletal**	☐ Joint pain ☐ Joint swelling ☐ Joint stiffness ☐ Low back pain ☐ Neck pain
ENT	☐ Nosebleeds ☐ Cold symptoms ☐ Voice changes ☐ Hearing problems	**Neurology**	☐ Chronic headache ☐ Passing out ☐ Confusion ☐ Seizures ☐ Dizziness
Respiratory	☐ Chronic cough ☐ Shortness of breath ☐ Wheezing ☐ Loud snoring /stop breathing when sleeping	**Dermatology**	☐ Rash ☐ Worrisome moles ☐ Skin lesions
Cardiovascular	☐ Chest pain ☐ Leg swelling ☐ Palpitations (racing heart or skipped beats)	**Mental Health**	☐ Sadness ☐ Feeling anxious ☐ Chemical dependency ☐ Do you feel unsafe?
Gastroenterology	☐ Difficulty swallowing ☐ Heartburn ☐ Abdominal pain ☐ Nausea ☐ Diarrhea ☐ Constipation ☐ Blood in stools	**Endocrinology**	☐ Feeling too cold or too hot ☐ Frequently thirsty
Male Reproductive	☐ Concern for Sexually Transmitted Disease (STD) ☐ Testicular lump/pain ☐ Penile discharge or lump ☐ Problems with sexual function	**Hematology – Oncology**	☐ Swollen glands ☐ Easy bruising
Female Reproductive	☐ Concern for Sexually Transmitted Disease (STD) ☐ Breast lumps, breast concerns ☐ Abnormal vaginal discharge ☐ Painful intercourse ☐ Menstrual cycle concerns	**Additional Information**	I have an Advance Directive ☐ Yes ☐ No I am an Organ Donor ☐ Yes ☐ No I am interested in discussing: ☐ Advance Directive ☐ Organ donation