Boulder Medical Center

Review of Systems

Patient name: _____ Date of Birth: _____

Why are you seeing the provider today? _____

_____

Tobacco Status and Usage	Quantity/ Frequency	**Alcohol Usage**	Quantity/ Frequency	**Marijuana Usage**	Quantity/ Frequency
* Including electronic cigarettes					
___ Current every day smoker	_____	___ Yes	_____	___ Yes	_____
___ Current some day smoker	_____	___ Never		___ Never	
___ Former smoker	_____	___ Former		___ Former	
___ Never smoked		**Caffeine Usage**		**Exercise**	
		___ Yes	_____	___ Yes	
		___ No		___ No	

Please mark with an "X" any symptoms you are currently experiencing

Constitutional
___ Chills
___ Fatigue
___ Fever
___ General Discomfort
___ Night sweats
___ Weight Gain
___ Weight Loss

HEENT
___ Ear Drainage
___ Ear Pain
___ Eye Discharge
___ Eye Pain
___ Hearing Loss
___ Nasal Drainage
___ Sinus Pressure
___ Sore Throat
___ Visual Changes

Respiratory
___ Chronic Cough
___ Cough
___ Known TB Exposure
___ Shortness of Breath
___ Wheezing

Cardiovascular
___ Chest Pain
___ Leg pain with exercise
___ Edema
___ Palpitations

Gastrointestinal
___ Abdominal Pain
___ Blood in Stools
___ Change in Stools
___ Constipation
___ Diarrhea

Gastrointestinal (Cont.)
___ Heartburn
___ Loss of appetite
___ Nausea
___ Vomiting

Metabolic/Endocrine
___ Cold Intolerance
___ Heat Intolerance
___ Excessive Thirst
___ Excessive Hunger

Neurological
___ Dizziness
___ Extremity Numbness
___ Extremity Weakness
___ Gait Disturbance
___ Headache
___ Memory Loss
___ Seizures
___ Tremors

Psychiatric
___ Anxiety
___ Depression
___ Insomnia

Dermatology
___ Breast Discharge
___ Breast Lump
___ Brittle Hair
___ Brittle Nails
___ Hair Loss
___ Excessive Hairiness
___ Hives
___ Itching
___ Mole Changes
___ Rash
___ Skin Lesion

Musculoskeletal
___ Back Pain
___ Joint Pain
___ Joint Swelling
___ Muscle Weakness
___ Neck Pain

Hematologic / Lymphatic
___ Easy Bleeding
___ Easy Bruising
___ Swollen Glands

Immunologic
___ Contact Allergy
___ Environmental Allergies
___ Food Allergies
___ Seasonal Allergies

Genitourinary
___ Dribbling (male only)
___ Painful Urination
___ Blood in Urine
___ Excessive Urination
___ Slow Stream (male only)
___ Urinary Frequency
___ Urinary Incontinence
___ Urinary Retention

Reproductive – Male
___ Erectile Dysfunction
___ Penile Discharge
___ Sexual Dysfunction

Reproductive – Female
___ Abnormal Pap
___ Painful Periods
___ Painful Intercourse
___ Hot Flashes
___ Irregular Periods
___ Vaginal Discharge

Are there any other symptoms, conditions or concerns you wish to address today? _____

_____