BROOMFIELD MEDICAL ASSOCIATES, PC
Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in space provided

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay fever Y N
Drug allergies Y N
Other _____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal
Abdominal pain Y N
Nausea/Vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular
Chest pain Y N
Varicose Y N
High blood pressure Y N
Other _____

Integumentary
Skin rash Y N
Boils Y N
Persistent rash Y N
Other _____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Ear/Nose/Throat/Mouth
Ear infection Y N
Sore throat Y N
Sinus Problems Y N
Other _____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____

Hematologic/Lymphatic
Swollen glands Y N
Blood clotting problem Y N
Other _____

Psychologic
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have considered Suicide? Y N
Other _____

Physician: _____ Date: _____