Name: _____ Date: _____ ACCT#: _____
For office use only.

Ironwood Physicians, PC

REVIEW OF SYSTEMS

System Review

Please check if you are experiencing any of the following symptoms

GENERAL:
☐ Yes / ☐ No Chills
☐ Yes / ☐ No Fever
☐ Yes / ☐ No Fatigue
☐ Yes / ☐ No Generalized Weakness
☐ Yes / ☐ No Night sweats
☐ Yes / ☐ No Trouble Sleeping
☐ Yes / ☐ No Weight Gain
☐ Yes / ☐ No Weight loss

SKIN:
☐ Yes / ☐ No Bruising
☐ Yes / ☐ No Chronic Skin Condition
☐ Yes / ☐ No Itching
☐ Yes / ☐ No Lesions/Boils
☐ Yes / ☐ No Nail Changes
☐ Yes / ☐ No Rash
☐ Yes / ☐ No Sores

HEAD/NECK:
☐ Yes / ☐ No Discharge from Ears
☐ Yes / ☐ No Dry Mouth
☐ Yes / ☐ No Frequent Sore Throats
☐ Yes / ☐ No Hearing Loss
☐ Yes / ☐ No Hoarseness
☐ Yes / ☐ No Nose Bleeds
☐ Yes / ☐ No Ringing/Pain in Ears
☐ Yes / ☐ No Sores/Ulcers in Mouth
☐ Yes / ☐ No Vision Changes

MUSCULOSKELETAL/ MOVEMENT:
☐ Yes / ☐ No Back Pain
☐ Yes / ☐ No Decreased Range of Motion
☐ Yes / ☐ No History of Fractures
☐ Yes / ☐ No Wheelchair, Cane or Walker

BREAST:
☐ Yes / ☐ No Armpit Lumps/Masses
☐ Yes / ☐ No Breast Lumps/Masses
☐ Yes / ☐ No Nipple Discharge
☐ Yes / ☐ No Pain
☐ Yes / ☐ No Skin Changes

HEART/LUNG:
☐ Yes / ☐ No Chest Pain
☐ Yes / ☐ No Pain in Legs
☐ Yes / ☐ No Palpitations
☐ Yes / ☐ No Swollen Ankles
☐ Yes / ☐ No Cough
☐ Yes / ☐ No Coughing Blood
☐ Yes / ☐ No Shortness of Breath
☐ Yes / ☐ No Sleep w/Head Elevated
☐ Yes / ☐ No Sputum/Mucus
☐ Yes / ☐ No Use C-PAP at home
☐ Yes / ☐ No Use Oxygen at home
☐ Yes / ☐ No Wheezing

ENDOCRINE/LYMPHATIC:
☐ Yes / ☐ No Cold Intolerance
☐ Yes / ☐ No Excessive Hunger
☐ Yes / ☐ No Excessive Sweating
☐ Yes / ☐ No Excessive Thirst
☐ Yes / ☐ No Heat Intolerance
☐ Yes / ☐ No Hot Flashes
☐ Yes / ☐ No Joint/Bone Pain
☐ Yes / ☐ No Painful Lymph Nodes
☐ Yes / ☐ No Swollen Lymph Nodes
☐ Yes / ☐ No Sexual Dysfunction

NEUROLOGICAL:
☐ Yes / ☐ No Balance Problems
☐ Yes / ☐ No Claustrophobia
☐ Yes / ☐ No Dizziness
☐ Yes / ☐ No Fainting
☐ Yes / ☐ No Headaches
☐ Yes / ☐ No Numbness/Tingling
☐ Yes / ☐ No Seizures
☐ Yes / ☐ No Tremors

GYNECOLOGIC:
☐ Yes / ☐ No Irregular Periods
☐ Yes / ☐ No Painful Periods
☐ Yes / ☐ No Painful Intercourse
☐ Yes / ☐ No Vaginal Bleeding
☐ Yes / ☐ No Vaginal Discharge
☐ Yes / ☐ No Vaginal Dryness

KIDNEY/BLADDER:
☐ Yes / ☐ No Blood in Urine
☐ Yes / ☐ No Cloudy Urine
☐ Yes / ☐ No Frequency of Urination
☐ Yes / ☐ No Getting up at Night
☐ Yes / ☐ No Hesitancy of Urination
☐ Yes / ☐ No Incontinence
☐ Yes / ☐ No Leakage/Retention
☐ Yes / ☐ No Pain when Urinating
☐ Yes / ☐ No Passed Stones
☐ Yes / ☐ No Urgency of Urination

GASTROINTESTINAL:
☐ Yes / ☐ No Black/Tarry/Clay Stools
☐ Yes / ☐ No Bloating
☐ Yes / ☐ No Constipation
☐ Yes / ☐ No Diarrhea
☐ Yes / ☐ No Difficulty Swallowing
☐ Yes / ☐ No Heartburn
☐ Yes / ☐ No Hemorrhoids
☐ Yes / ☐ No Incontinence of Stool
☐ Yes / ☐ No Nausea
☐ Yes / ☐ No Painful Swallowing
☐ Yes / ☐ No Poor Appetite
☐ Yes / ☐ No Rectal Bleeding
☐ Yes / ☐ No Vomiting
☐ Yes / ☐ No Vomiting Blood
☐ Yes / ☐ No Yellowing of Skin/Eyes

PSYCHOLOGIC:
☐ Yes / ☐ No Anxiety
☐ Yes / ☐ No Depression
☐ Yes / ☐ No Memory Changes
☐ Yes / ☐ No Nervousness