inSite
DIGESTIVE HEALTH CARE

Review of Systems

Patient Name: _____ Date of Birth: _____

What is the reason for your visit? _____

Constitutional		
☐ None		
	fatigue	Y N
	fever	Y N
	loss of appetite	Y N
	weight gain	Y N
	weight loss	Y N

Gastrointestinal		
☐ None		
	abdominal pain	Y N
	abdominal bloating	Y N
	change in bowel habits	Y N
	constipation	Y N
	diarrhea	Y N
	gas pain or excess	Y N
	heartburn	Y N
	jaundice	Y N
	nausea/vomiting	Y N
	rectal bleeding	Y N
	stomach cramps	Y N
	difficulty swallowing	Y N
	vomiting blood	Y N
	black, tarry stool	Y N
	hemorrhoids	Y N

Eyes		
☐ None		
	double vision	Y N
	loss of vision	Y N

Ear, Nose, Throat		
☐ None		
	nose bleeds	Y N
	sore throat	Y N

Respiratory		
☐ None		
	asthma	Y N
	cough	Y N
	shortness of breath	Y N
	excessive sputum/phlegm	Y N
	coughing up blood	Y N

Cardiovascular		
☐ None		
	chest pain or angina	Y N
	irregular heart beat	Y N
	palpitations	Y N
	edema/ankles swell	Y N
	faint/lose consciousness	Y N

Genitourinary		
☐ None		
	painful urination	Y N
	frequent urinary infections	Y N
	frequent urination	Y N
	blood in urine	Y N
	sexual function problem	Y N
	persistant discharge	Y N
	loss of control	Y N
	kidney stones	Y N
	pelvic pain	Y N
	heavy menstruation	Y N
	pain during intercourse	Y N
	difficult urine flow	Y N

Hematologic/Lymphatic		
☐ None		
	easy bruising	Y N
	prolonged bleeding	Y N
	enlarged lymph nodes	Y N

Endocrine		
☐ None		
	excessive thirst	Y N

Integumentary		
☐ None		
	itching	Y N
	rashes	Y N

Staff Notes:	

Allergic/Immunologic		
☐ None		
	strong allergic reactions or hives	Y N

Musculoskeletal		
☐ None		
	arthritis	Y N
	back pain	Y N
	joint pain	Y N
	muscle weakness	Y N

Neurological		
☐ None		
	dizziness	Y N
	fainting	Y N
	frequent headaches	Y N
	migraine	Y N
	numbness or tingling	Y N
	tremors	Y N
	vertigo	Y N
	memory loss	Y N
	falls	Y N

Psychiatric		
☐ None		
	anxiety	Y N
	depression	Y N
	difficulty sleeping	Y N
	panic attacks	Y N
	currently seeing therapist	Y N

Other

_____ _____

Patient Signature Date