

REVIEW OF SYSTEMS -MALE
DATE_____

NAME: _____ DATE OF BIRTH_____

DATE OF LAST EYE EXAM: _____

DATE OF LAST DENTAL EXAM: _____

DATE OF LAST TETANUS VACCINE: _____

HAVE YOU HADA PNEUMOVAX: _____ WHEN: _____

WHAT WAS YOUR LAST CHOLESTEROL: _____ WHEN: _____

DO YOU HAVE A LIVING WILL: _____?

Have you had: any unusual weight loss? YES NO
 any unusual fatigue? YES NO
 persistent fever? YES NO

 Have you had blurred vision? YES NO
 Do you wear glasses/contact lenses? YES NO
 Have you had eye pain, redness or
 excessive tearing? YES NO
 Do you have glaucoma? YES NO
 Do you have cataracts? YES NO
 Have you had eye surgery? YES NO

Do you have: hearing trouble? YES NO
 ringing in your ears? YES NO
 hay fever? YES NO
 bleeding gums? YES NO
 persistent hoarseness? YES NO

Do you have: breast lumps or discharge? YES NO
 persistent rashes? YES NO

Do you have: heart trouble? YES NO
 high blood pressure? YES NO
 shortness of breath when you lay down? YES NO
 swelling in your extremities? YES NO
 chest pain? YES NO
 palpitations? YES NO
 leg pain with prolonged walking? YES NO
 Have you had an EKG or heart tests? YES NO
 Have you had rheumatic fever? YES NO

(CONTINUED ON BACK)

Do you have:	trouble swallowing?	YES	NO
	heartburn?	YES	NO
	blood in your bowel movements or black, tarry bowel movements?	YES	NO
	constipation or diarrhea?	YES	NO
	abdominal pain?	YES	NO
	Have you had hepatitis or jaundice?	YES	NO
	Do you vomit blood?	YES	NO
	Have you had a change in bowel habits?	YES	NO
Do you have:	Have you ever been sexually active?	YES	NO
	Any sexual difficulties?	YES	NO
	Burning on urination?	YES	NO
	Blood in your urine?	YES	NO
	Have you had sexually transmitted diseases?	YES	NO
	Have you had trouble with erections?	YES	NO
Do you have:	any joint pains or stiffness?	YES	NO
	arthritis?	YES	NO
	gout?	YES	NO
	backache?	YES	NO
Do you have:	seizures?	YES	NO
	paralysis?	YES	NO
	any numbness or tingling?	YES	NO
	tremors?	YES	NO
	memory loss or trouble with memory?	YES	NO
Do you have:	nervousness or tension?	YES	NO
	depression?	YES	NO
	alcohol or drug dependency?	YES	NO
	tobacco/nicotine dependency?	YES	NO
	trouble sleeping?	YES	NO
Do you have:	thyroid trouble?	YES	NO
	diabetes mellitus?	YES	NO
	excessive thirst?	YES	NO
	excessive hunger?	YES	NO
	excessive urination?	YES	NO
Have you had:	anemia?	YES	NO
	easy bruising or bleeding?	YES	NO
	a blood transfusion?	YES	NO
	swollen glands?	YES	NO
Have you had:	any allergies?	YES	NO
	Problems with recurrent infections?	YES	NO