



Review of Systems Worksheet

Patient Name: _____ Date: _____

Do you use tobacco products? No Yes; If yes, what kind? _____

If yes, would you like to quit? No Yes

Check all of the following that have occurred within the past year OR since your last visit.

1. General

- No problems
- Fever or chills
- Night sweats
- Unexplained hair loss (alopecia)

2. Eyes

- No problems
- Vision problems (blurred vision, loss of vision)
- Eye pain

3. Ears/Mouth/Throat

- No problems
- Dizziness
- Mouth sores
- Swollen glands in neck
- Sore throat/pain when swallowing
- Dental (teeth/gum) problems

4. Cardiovascular (Heart/Circulation)

- No problems
- Chest pain (sharp, crushing, or heaviness)
- Heart racing (palpitations)
- Sudden shortness of breath at night or lying down
- Aching/Burning in legs
- Fainting spells
- Swelling of legs (edema)

5. Respiratory (Lungs/Breathing)

- No problems
- Shortness of breath
- Cough/coughing up blood

6. Gastrointestinal (Stomach/Bowels)

- No problems
- Stomach pain
- Change in appetite
- Diarrhea
- Nausea/Vomiting

7. Genitourinary (Urinary/Sexual)

Men and Women:

- No problems
 - Pain when passing water (urination)
 - Passing water more than usual (day and/or night)
 - Pain during sex
 - Sores (vagina, penis, rectum)
 - Blood in urine
 - Bladder Infection/other infections
 - Changes in sex drive (libido)
- Women:*
- Changes in your period (menstruation)
 - Discharge from vagina
 - Douching
 - Painful periods (menstruation)
 - Three or more yeast infections in a year
- Men:*
- Discharge from penis (drip)
 - Swelling in balls (scrotum)

8. Musculoskeletal (Muscles/Bones)

- No problems
- Joint pain
- Numbness, tingling, or weakness in arms or legs
- Limited motion of arms or legs
- Swelling/Redness/Pain in calf or thigh

PLEASE TURN OVER AND COMPLETE SIDE 2.

9. Neurological

- No problems
- New headaches
- Repeated bad headaches
- Headaches with vision changes
- Problems with memory or speech

10. Psychiatric/Social

- No problems
- Felt unsafe with anyone
- Tried to harm yourself/others
- Experienced sexual or physical abuse
- Seeing or hearing things (hallucinations)
- Suicidal thoughts
- Depression/Anxiety
- Mood swings

11. Endocrine

- No problems
- Thirsty all the time
- Increased facial hair (females only)
- Weight gain/loss
- Can not stand temperature changes (heat/cold)

12. Lymph (Glands)

- No problems
- Swollen glands (armpits or groin)

13. Skin

- No problems
- Rash (palm of hands, sole of feet)
- Pain/Redness/Swelling, **If so, where:** _____
- Sores, **If so, where:** _____
- Changes in skin

14. Allergies

- No problems
- Hives
- Allergic reaction to medications/drugs/latex
- Allergic reaction to foods

15. OtherPlease write in:

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Review of Systems Worksheet- DHEC 0786

(Instructions for Completing)

(5/2010)

Purpose: To provide a uniform system for collecting client's interval history including review of systems. Information collected will be used in the delivery of health services.

Explanation and Definition:

The form is to be used for patients receiving public health services. The extent of the information collected will depend on the patient and the reason for services. All items are to be completed in pen. Refer to program guidelines to determine when this form is to be completed.

General Instructions for Use:

The Review of Systems Worksheet is to be completed by the patient or caregiver. If the patient or caregiver is not able to complete the form, the health care provider will complete it. Refer to program guidelines to determine when this form is to be completed.

The patient will complete the appropriate sections.

Upon completion of the form by the patient or caregiver, the health care provider will review the worksheet. Pertinent questions are asked to clarify the information provided. The health care provider will document pertinent information on the Clinical Encounter Form (DHEC 3212).

Office Mechanics and Filing:

Once the health care provider has reviewed the form, the original should be shredded. The form is not to be filed in the Comprehensive Health Record. It is only utilized for data collection purposes, then shredded.