VICTORY PHYSICIANS

Preventive Care Review of Systems

A quality preventive care program for our patients begins with a complete review of systems. Please take 5 to 10 minutes to complete the following questionnaire to the best of your ability.

Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS									
Constitutional									
Y ☐	N ☐	Fever	Y ☐	N ☐	Chills	Y ☐	N ☐	Night sweats
Y ☐	N ☐	Malaise	Y ☐	N ☐	Weakness	Y ☐	N ☐	Faintness
Y ☐	N ☐	Anorexia	Y ☐	N ☐	Increased thirst	Y ☐	N ☐	Weight gain
Y ☐	N ☐	Weight loss	Y ☐	N ☐	Insomnia	Y ☐	N ☐	Loss of interest
Y ☐	N ☐	Distracted	Y ☐	N ☐	Poor work performance			
Cardiology									
Y ☐	N ☐	Chest pain	Y ☐	N ☐	Short of breath	Y ☐	N ☐	Almost passing out
Y ☐	N ☐	Passing out	Y ☐	N ☐	Weight gain	Y ☐	N ☐	Leg swelling
Y ☐	N ☐	Sweating	Y ☐	N ☐	Feeling doom	Y ☐	N ☐	Palpitations
Y ☐	N ☐	Dizziness	Y ☐	N ☐	Weakness	Y ☐	N ☐	Fatigue
Y ☐	N ☐	Night breath loss	Y ☐	N ☐	Cough			
Allergy									
Y ☐	N ☐	Rash	Y ☐	N ☐	Face swelling	Y ☐	N ☐	Tongue swelling
Y ☐	N ☐	Voice change	Y ☐	N ☐	Wheezing	Y ☐	N ☐	Cough
Y ☐	N ☐	Shortness breath	Y ☐	N ☐	Hard to breathe	Y ☐	N ☐	Itchy eyes
Y ☐	N ☐	Itchy nose	Y ☐	N ☐	Congestion	Y ☐	N ☐	Post nasal drip
Y ☐	N ☐	Sneezing	Y ☐	N ☐	Sore throat	Y ☐	N ☐	Sinus pressure
Y ☐	N ☐	Nose bleeds	Y ☐	N ☐	Eye fullness			
Gastrointestinal (GI)									
Y ☐	N ☐	Abdominal pain	Y ☐	N ☐	Pelvic pain	Y ☐	N ☐	Mass
Y ☐	N ☐	Hernia	Y ☐	N ☐	Nausea	Y ☐	N ☐	Vomiting
Gastrointestinal (GI) Continued									
Y ☐	N ☐	Blood in vomit	Y ☐	N ☐	Heart burn	Y ☐	N ☐	Blood in stool
Y ☐	N ☐	Tarry stools	Y ☐	N ☐	Brown vomit	Y ☐	N ☐	Hard to swallow
Y ☐	N ☐	Diarrhea	Y ☐	N ☐	Constipation	Y ☐	N ☐	Hemorrhoids
Y ☐	N ☐	Painful defecation	Y ☐	N ☐	Excess gas	Y ☐	N ☐	No gas
Y ☐	N ☐	Loud bowel sounds	Y ☐	N ☐	Anorexia	Y ☐	N ☐	Excess eating

Name: _____ Date of Birth: _____

Musculoskeletal		
Y☐ N☐ Muscle pain	Y☐ N☐ Joint pain	Y☐ N☐ Muscle swelling
Y☐ N☐ Joint swelling	Y☐ N☐ Muscle stiffness	Y☐ N☐ Muscle cramps
Y☐ N☐ Joint crunching	Y☐ N☐ Joint locking up	Y☐ N☐ Joint giving away
Y☐ N☐ Joint redness	Y☐ N☐ Decreased motion	Y☐ N☐ Excessive motion
Y☐ N☐ Pain on motion		
Ears, Nose and Throat (ENT)		
Y☐ N☐ Ear pain	Y☐ N☐ Ear fullness	Y☐ N☐ Ear discharge
Y☐ N☐ Hearing loss	Y☐ N☐ Runny nose	Y☐ N☐ Itchy nose
Y☐ N☐ Bloody nose	Y☐ N☐ Nasal congestion	Y☐ N☐ Sore throat
Y☐ N☐ Bad breath	Y☐ N☐ Tooth pain	Y☐ N☐ Mass or growth
Y☐ N☐ Pain	Y☐ N☐ Hoarseness	Y☐ N☐ Tongue swelling
Y☐ N☐ Voices changes	Y☐ N☐ Ear ringing	Y☐ N☐ Sinus Pain
Y☐ N☐ Post nasal drip	Y☐ N☐ Sinus pressure	Y☐ N☐ Headache
Y☐ N☐ Swollen nodes		
Endocrinology		
Y☐ N☐ Excess eating	Y☐ N☐ Excess urination	Y☐ N☐ Excess thirst
Y☐ N☐ Excess sweating	Y☐ N☐ Cold intolerance	Y☐ N☐ Heat tolerance
Y☐ N☐ Fatigue	Y☐ N☐ Agitation	Y☐ N☐ Weight loss
Y☐ N☐ Weight gain	Y☐ N☐ Lethargy	Y☐ N☐ Insomnia
Y☐ N☐ Excess sleeping	Y☐ N☐ Hair loss	Y☐ N☐ Skin changes
Y☐ N☐ Constipation	Y☐ N☐ Diarrhea	Y☐ N☐ Palpitations
Y☐ N☐ Slow heart rate	Y☐ N☐ Anorexia	
Respiratory		
Y☐ N☐ Dry cough	Y☐ N☐ Productive cough	Y☐ N☐ Bloody cough
Y☐ N☐ ↑ Breath on exert	Y☐ N☐ Chest congestion	Y☐ N☐ Chest pain
Y☐ N☐ Wheezing	Y☐ N☐ Positional breath ↓	Y☐ N☐ Night breath loss
Y☐ N☐ Short of breath		
Urology		
Y☐ N☐ Urgency	Y☐ N☐ Decreased stream	Y☐ N☐ Dribbling
Y☐ N☐ Trouble starting	Y☐ N☐ Trouble stopping	Y☐ N☐ Pain with urination
Y☐ N☐ Frequency	Y☐ N☐ Hematuria	Y☐ N☐ ↓ Urinary control
Y☐ N☐ Stones/Sediment	Y☐ N☐ Nocturia	Y☐ N☐ Testicle mass
Y☐ N☐ Testicle pain	Y☐ N☐ Scrotal pain	Y☐ N☐ Scrotal mass
Y☐ N☐ Rash	Y☐ N☐ Unable to ejaculate	Y☐ N☐ ↓ Ejaculate
Y☐ N☐ Bloody ejaculate		
Neurology		
Y☐ N☐ Dizziness	Y☐ N☐ Gait abnormality	Y☐ N☐ Headache
Y☐ N☐ Insomnia	Y☐ N☐ Memory loss	Y☐ N☐ Numbness
Y☐ N☐ Seizures	Y☐ N☐ Tingling	

Name: _____ Date of Birth: _____

Ophthalmology								
Y ☐	N ☐	Halos	Y ☐	N ☐	Floaters	Y ☐	N ☐	Field cuts
Y ☐	N ☐	Vision loss	Y ☐	N ☐	Blurred vision	Y ☐	N ☐	Double vision
Y ☐	N ☐	Red eye(s)	Y ☐	N ☐	Irritated eye(s)	Y ☐	N ☐	Drainage eye(s)
Y ☐	N ☐	Pain in eye(s)	Y ☐	N ☐	Periorbital redness	Y ☐	N ☐	Periorbital swelling
Y ☐	N ☐	Dry eye	Y ☐	N ☐	↑ Tears in eye(s)	Y ☐	N ☐	↓ Night vision
Y ☐	N ☐	Photophobia	Y ☐	N ☐	Shifting vision	Y ☐	N ☐	Trouble focusing
Y ☐	N ☐	Losing near vision	Y ☐	N ☐	Losing far vision			
Hematology/Lymphatic								
Y ☐	N ☐	Swollen glands	Y ☐	N ☐	Swollen nodes	Y ☐	N ☐	Fatigue
Y ☐	N ☐	Malaise	Y ☐	N ☐	New lumps/bumps	Y ☐	N ☐	Anorexia
Y ☐	N ☐	Weight loss	Y ☐	N ☐	Easy bruising	Y ☐	N ☐	Rash
Female Reproduction								
Y ☐	N ☐	Heavy periods	Y ☐	N ☐	Irregular periods	Y ☐	N ☐	Irreg. heavy period
Y ☐	N ☐	No periods	Y ☐	N ☐	Vaginal itch	Y ☐	N ☐	Vaginal discharge
Y ☐	N ☐	Vaginal lesion(s)	Y ☐	N ☐	Pelvic pain	Y ☐	N ☐	Pelvic mass
Y ☐	N ☐	Hot flashes	Y ☐	N ☐	Irritability	Y ☐	N ☐	Painful periods
Y ☐	N ☐	Breast pain	Y ☐	N ☐	Breast mass	Y ☐	N ☐	Nipple discharge
Y ☐	N ☐	Breast rash						
Male Reproduction								
Y ☐	N ☐	Erectile difficulty	Y ☐	N ☐	Penile discharge	Y ☐	N ☐	Painful urination
Y ☐	N ☐	↓ libido	Y ☐	N ☐	Urgency	Y ☐	N ☐	Frequent urination
Y ☐	N ☐	↓ ejaculate	Y ☐	N ☐	Bloody ejaculate	Y ☐	N ☐	Testicle pain
Y ☐	N ☐	Testicle mass						
Dermatology								
Y ☐	N ☐	Rash	Y ☐	N ☐	Lumps	Y ☐	N ☐	Bumps
Y ☐	N ☐	Dry skin	Y ☐	N ☐	Scaly skin	Y ☐	N ☐	Bleeding lesion(s)
Y ☐	N ☐	Weeping lesion(s)	Y ☐	N ☐	Oozing lesion(s)	Y ☐	N ☐	Growing lesion(s)
Y ☐	N ☐	Changing lesion(s)	Y ☐	N ☐	Painful lesion(s)	Y ☐	N ☐	Odd color lesion(s)
Y ☐	N ☐	Nail thickening	Y ☐	N ☐	Nail discoloration	Y ☐	N ☐	Nail pallor
Y ☐	N ☐	Itching						
Psychology								
Y ☐	N ☐	Depression	Y ☐	N ☐	Anxiety	Y ☐	N ☐	Agitation
Y ☐	N ☐	Mania	Y ☐	N ☐	Suicidal ideation	Y ☐	N ☐	Want to kill
Y ☐	N ☐	Excessive stressors	Y ☐	N ☐	Paranoia	Y ☐	N ☐	Excess sleep
Y ☐	N ☐	Anorexia	Y ☐	N ☐	Bulimia	Y ☐	N ☐	Mental abuse
Y ☐	N ☐	Hearing voices	Y ☐	N ☐	Seeing things	Y ☐	N ☐	Physical abuse

Patient Signature _____ Date _____

Reviewed by Physician _____ Date _____