NAME:_____ **DATE:**_____

REVIEW OF SYSTEMS

Nurse: Please give to patient. Please place patient hospital sticker above to left. When completed, please fax directly to Alpine Orthopaedic and Spine at 509-435-0978.
Patient: Place a check next to each item you have experienced in the last month. After completion, please give to nurse to fax to clinic.

Constitution

	Fever
	Chills
	Weight loss
	Malaise/Fatigue
	Diaphoresis
	Weakness

Skin

	Rash
	Itching

HENT

	Hearing loss
	Tinnitus
	Ear pain
	Ear discharge
	Nosebleeds
	Congestion
	Sinus pain
	Stridor
	Sore throat

Eyes

	Blurred vision
	Double vision
	Photophobia
	Eye pain
	Eye discharge
	Eye redness

Cardiovascular

	Chest pain
	Palpitations
	Orthopnea
	Claudication
	Leg swelling
	PND

Respiratory

	Cough
	Hemoptysis
	Sputum production
	Shortness of breath
	Wheezing

GI

	Heartburn
	Nausea
	Vomiting
	Abdominal pain
	Diarrhea
	Constipation
	Blood in stool
	Melena

NAME:_____ DATE:_____

GU

	Dysuria
	Urgency
	Frequency
	Hematuria
	Flank pain

Musculoskeletal

	Myalgias
	Neck pain
	Back pain
	Joint pain
	Falls

Endo/Heme/Aller

	Easy bruise/bleed
	Env allergies
	Polydipsia

Neurological

	Dizziness
	Headaches
	Tingling
	Tremor
	Sensory change
	Speech change
	Focal weakness
	Seizures
	LOC

Psychiatric

	Depression
	Suicidal ideas
	Substance abuse
	Hallucinations
	Nervous/Anxious
	Insomnia
	Memory loss

Reasons ROS cannot be performed:

	Acuity of condition
	Age
	Critical illness
	Dementia
	Intubated
	Language
	Medical condition
	Mental acuity
	Mental status change
	Patient nonverbal
	Patient unresponsive
	Psychiatric disorder
	Severe respiratory distress
	Severity of pain
	Unstable vital signs
	Other