

REVIEW OF SYSTEMS (ROS) QUESTIONNAIRE
MEDICAL HISTORY

Please indicate **YES** or **NO** if you have now, or in the past, had any problems with your health related to the following systems. Please indicate date of illness, and a brief explanation in the space provided.

Name: _____ **CIRCLE YOUR RESPONSE**
Height _____ Weight _____

Heart/Blood Pressure no yes _____
Date of Last EKG _____ Where performed? _____

Lungs/ Breathing Problems no yes _____
Do you smoke? no yes Amount per day _____

Digestive Problems no yes _____

Liver Disease no yes _____
Do you drink alcohol? no yes Amount per week _____
Have you had hepatitis? no yes Type _____ Date _____

Urinary/Kidney Problems no yes _____

Gynecological Problems no yes _____

Endocrine Problems no yes _____
Diabetes no yes Date of Onset _____
If yes, how often do you check your blood sugar? _____
What method do you use? _____
Thyroid Condition no yes _____

Neurological Problems no yes _____
Dizzy spells, blackouts or seizures? no yes How often? _____
Emotional problems no yes _____

Bleeding Disorder or Prolonged bleedings no yes _____

Do you wear contact lenses? no yes Left eye Right eye Both
Do you have a hearing problem? no yes _____
Do you wear a hearing aid? no yes Left ear Right ear Both
Do you have any loose teeth, removal bridges or dentures? no yes Upper Lower Both

Any other health problems? Please comment: _____

Do you have a family or primary care physician that you see regularly?
Name _____ Phone _____ Last seen _____

Patient Signature _____ Date _____

see next page