

## NP Intake Review of Systems

**Name:** \_\_\_\_\_

**Have you had trouble with any of the following:**

**Cardiovascular:**

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

**Genitourinary:**

	No _____		
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

**Hematologic/Lymphatic:**

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

**Neurologic:**

	No _____		
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

**Respiratory:**

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

**Ears/Nose/Throat:**

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

**Eyes:**

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

**Integumentary:**

	No _____		
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

**Psychiatric:**

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

**Constitutional:**

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

**Allergic/Immunologic:**

	No _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

**Gastrointestinal:**

	No _____		
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

**Musculoskeletal:**

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

**Endocrine:**

	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			