

Monterey Bay Urology / Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**

Please explain any Yes answers in the space provided.

Constitutional Symptoms				Skin			
Fever	Yes	No		Skin Rash	Yes	No	
Chills	Yes	No		Boils	Yes	No	
Headache	Yes	No		Persistent Itch	Yes	No	
Other				Other			
Eyes				Musculoskeletal			
Blurred Vision	Yes	No		Joint Pain	Yes	No	
Double Vision	Yes	No		Neck Pain	Yes	No	
Pain	Yes	No		Back Pain	Yes	No	
Other				Other			
Allergic/Immunologic				Ears/Nose/Throat/Mouth			
Hay Fever	Yes	No		Ear Infection	Yes	No	
Drug Allergies	Yes	No		Sore Throat	Yes	No	
Other				Sinus Problems	Yes	No	
Neurological				Other			
Tremors	Yes	No					
Dizzy Spells	Yes	No		Respiratory			
Numbness/Tingling	Yes	No		Wheezing	Yes	No	
Other				Frequent cough	Yes	No	
Endocrine				Shortness of breath			
Excessive Thirst/Sweating	Yes	No		Shortness of breath	Yes	No	
Too Hot/Cold	Yes	No		Other			
Tired/Sluggish	Yes	No		Hematologic/Lymphatic			
Other				Swollen glands	Yes	No	
Gastrointestinal				Blood clotting problem			
Abdominal pain	Yes	No		Blood clotting problem	Yes	No	
Nausea/Vomiting	Yes	No		Other			
Indigestion/heartburn	Yes	No		Psychologic			
Other				Are you generally satisfied with your life?	Yes	No	
Cardiovascular				Do you feel severely depressed?			
Chest pain	Yes	No		Do you feel severely depressed?	Yes	No	
Varicose Veins	Yes	No		Have you considered suicide?	Yes	No	
High Blood Pressure	Yes	No		Have you considered suicide?	Yes	No	
Other				Other			

Physician use only: (Comments/Notes)

	#Answer	Level of Service
	0-1	1 or 2
	2-9	3
	10+	4or5

Physician: _____	Date	/ / _____
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