



Review of Systems/ Revision De Sistemas

Patient: _____

Date: _____

Do you now have or have you had any problems related to the following symptoms? Circle Yes or No
Tiene usted o ha tenido alguno de los síntomas a continuación? Circula SI o NO

Constitutional/ Síntomas Mas Usuales:

Fever/ *Fiebre* [Yes No] [Si No]
Chills/ *Escalofríos* [Yes No] [Si No]
Headache/ *Dolor de cabeza* [Yes No] [Si No]
Other/ *Otro:* _____

Integumentary/ Cardiovascular:

Skin Rash/ *Erupción de la piel* [Yes No] [Si No]
Boils/ *Ampollas* [Yes No] [Si No]
Presistent Itch/ *Persistente pica* [Yes No] [Si No]
Other/ *Otro:* _____

Eyes/ Ojos:

Blurred Vision/ *Visión nublada* [Yes No] [Si No]
Double Vision/ *Visión Doble* [Yes No] [Si No]
Pain/ *Dolor* [Yes No] [Si No]
Other/ *Otro:* _____

Muscular Skeletal/ Esquelético muscular:

Joint Pain/ *Dolor común* [Yes No] [Si No]
Neck Pain/ *Dolor de cuello* [Yes No] [Si No]
Back Pain/ *Dolor de espalda* [Yes No] [Si No]
Other/ *Otro:* _____

Allergic/ Alergias:

Hay Fever/ *Fiebre Del Heno* [Yes No] [Si No]
Drug Allergies/
Alergias a ciertos Medicamentos [Yes No] [Si No]
Other/ *Otro:* _____

Ear/Nose/Throat/Mouth/ Oído/Nariz/Garganta/Boca:

Ear Infection/ *Infección de Oído* [Yes No] [Si No]
Sore Throat/ *Dolor de Garganta* [Yes No] [Si No]
Sinus Problem/ *Sinusitis* [Yes No] [Si No]
Other/ *Otro:* _____

Neurological/ Neurológico:

Tremors/ *Temblores* [Yes No] [Si No]
Dizzy Spells/ *Mareos* [Yes No] [Si No]
Numbness-Tingling/ *Entumecimiento* [Yes No] [Si No]
Other/ *Otro:* _____

Genitourinary/ Genitourinario:

Urine retention/ *Retención de orine* [Yes No] [Si No]
Painful Urination/ *Orina dolorosa* [Yes No] [Si No]
Urinary Frequency/ *Orina Frecuentemente* [Yes No] [Si No]
Other/ *Otro:* _____

Endocrine/ Endocrina:

Excessive thirst/ *Sed Excesiva* [Yes No] [Si No]
Too Hot-Cold/ *Mucho Frio-Calor* [Yes No] [Si No]
Tired-Sluggish/ *Cansancio/ Desanimo* [Yes No] [Si No]
Other/ *Otro:* _____

Respiratory/Respiratorio:

Wheezing/ *El Wheezing* [Yes No] [Si No]
Frequent Cough/ *Tos Frecuente* [Yes No] [Si No]
Shortness of breath/ *Falta de aire* [Yes No] [Si No]
Other/ *Otro:* _____

Gastrointestinal/ Gastrointestinal:

Abdominal Pain/ *Dolor Abdominal* [Yes No] [Si No]
Nausea-Vomiting/ *Nauseas-Vómitos* [Yes No] [Si No]
Indigestion-Heartburn/ *Indigestion-Acidez* [Yes No] [Si No]
Other/ *Otro:* _____

Hematologic/ Lymphatic:

Swollen Glands/ *Glandulas Inflamadas* [Yes No] [Si No]
Blood Clotting Problem/ *Coagulos Sanguineos* [Yes No] [Si No]
Other/ *Otro:* _____

Cardiovascular/ Cardiovascular:

Chest Pain/ *Dolor de pecho* [Yes No] [Si No]
Varicose Veins/ *Venas Varicosas* [Yes No] [Si No]
High Blood Pressure/ *Presión Alta* [Yes No] [Si No]

Psychologic/ Sicológico:

Are you unhappy with your life?
Esta usted contento con su vida? [Yes No] [Si No]
Do you feel severely Depressed?
Esta usted sumamente Deprimido? [Yes No] [Si No]
Have you considered suicide?
Ha considerado el suicidio? [Yes No] [Si No]