



## Review of Systems/ Revision De Sistemas

Paciente: \_\_\_\_\_

Fecha: \_\_\_\_\_

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/ Desanimado* [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/ Sicológica:**

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]