

REVIEW OF SYSTEMS (ROS)

The goal of the ROS is to provide an opportunity to discover any active medical problems not previously discussed and to identify any additional symptoms that may be related to the presenting complaint of the patient. Therefore the ROS is essentially an organized survey of systems based on a review of current symptoms. **The patient is instructed to answer either “yes” or “no” if appropriate and should be instructed as to the time frame under consideration (i.e., past three to six months).** The ROS is the final checklist to make sure that no significant problems have been overlooked in obtaining the history. Active problems not considered to be relevant to the presenting complaint should be placed here rather than in the HPI. If a major new problem is revealed during the ROS that an appropriately detailed historical evaluation should be completed. Remember to inform the patient that you will be asking these routine questions to insure completeness of the information not specifically because of the patient’s complaints or physical examination findings. This approach will help to put the patient at ease and diminish anxiety.

Describe the specific symptom evaluated: (use laymen’s terms familiar to patient, terms presented here are for professional use)

General Review Of Systems (ROS)

Have you had any fever?
Have you had any chills?
Have you had any (night) sweats?
Have you had any weight loss or weight gain?
Have you been tired or fatigued?

Dermatologic ROS

Have you noticed a rash or skin lesion? Does it itch or burn?
Have you noticed any changes in skin dryness?
Have you had any changes in moles (size, color, border irregularity)?
Have you had any changes in hair texture?
Have you had any changes in nails?

Head And Neck ROS

Have you had any headaches? Where?
Have you had any neck pain?
Have you noticed any neck masses or “swollen glands”?
Have you had any neck stiffness?
Have you had any dizziness or lightheadedness?

ROS for Ears

Have you had any hearing loss?
Do you use hearing aid(s)?
Have you had any ear pain or earaches?
Have you had any ringing in the ears (tinnitus)?
Have you had any discharge/blood/pus from the ears?

ROS for The Nose & Sinuses

Have you had any nasal discharge? What color?
Have you had any nose bleeds (epistaxis)?
Have you had any sinus pains or pressure?
Have you had any post-nasal drip?

ROS for Throat & Oral Cavity

Have you had any sores in your mouth?
Have you had any tooth or gum problems?
Have you had a sore throat?
Have you noticed any hoarseness?
Do you wear dentures?

ROS for Eyes

Have you had a change in vision?
Do you use glasses or contact lenses?
Have you had any double vision (diplopia)?
Have you had blurred vision?
Any redness of your eyes?
Any discharge from your eyes?
Any excessive tearing or dryness in your eyes?
Have you had any trauma to your eyes?

Breast ROS

Have you noticed any lumps/masses
Have you had any breast pain?
Have you had any discharge from the nipple

Pulmonary ROS

Have you had a (new/different) cough?
Have you brought up any phlegm? What color?
Have you coughed up blood (hemoptysis)?
Have you had pain with breathing (pleuritic pain)?
Have you had shortness of breath?
Have you had any wheezing?

Cardiovascular ROS

Have you had any chest pain?
Have you been short of breath?
*with exertion (dyspnea on exertion)
*while lying flat (orthopnea)
*suddenly while sleeping (paroxysmal nocturnal dyspnea)
Have you had any palpitations?
Have you had any swelling in legs or feet (edema)?
Have you had any pain in the calves while walking (claudication)?

ABDOMINAL ROS (Gastrointestinal)

Have you had any difficulty swallowing (dysphagia)?
Have you had pain on swallowing (odynophagia)?
Have you had any heartburn? (Characterize it further)
Are you having any abdominal pain?
Have you had a loss of appetite (anorexia)?
Have you had any nausea?
Have you had any vomiting?
Have you had any diarrhea?
Have you had any constipation?
Have you noticed a change in bowel habits?

ABDOMINAL ROS (Gastrointestinal) Continued

Have you had any black, tarry stools (melena)?
Have you had any bloody stools (hematochezia) or bright red blood per rectum (BRBPR)?
Have you noticed a change in the caliber of stool size?
Have you noticed your skin or eyes turning yellow (jaundice)?
Have you had hemorrhoids?
Have you noticed any easy bleeding or bruising?

Urinary (Male/Female)

Have you had to urinate more frequently?
Do you feel the urge to urinate more often (urgency)?
Have you had any pain or burning on urination (dysuria)?
Have you noticed any blood in urine (hematuria)?
Have you had any problem with loss of urine or bladder control (urinary incontinence)?
Do you wake up at night to urinate (nocturia)? How often?
Have you had a change in urine color or odor?

GYNECOLOGICAL

Describe the frequency, regularity, discomfort and heaviness of menses
Have you any change in the discomfort/pain with menses?
Have you had post-menopausal bleeding
Have you had any "hot flashes"?
Have you noticed vaginal dryness?

MALE GU

Have you had difficulty starting the stream?
Have you noticed any lesions on the penis?
Have you had any penile discharge?
Have you had any problems with erection?
Have you had any problems with fertility?
Have you noticed a change in libido?
Have you noticed a scrotal or testicular mass?

SEXUAL HISTORY (May be asked in psychosocial history section)

Screening Questions:

1. Are you sexually active?
2. Have you noticed any changes or problems in your sexual functioning?
3. Has illness (if applicable) affected your sexual functioning?
4. Are you using condoms to prevent disease?
5. Are you using birth control - what type?
6. Are you in a monogamous relationship?
7. For men: Have you had any problems developing or maintaining an erection?
Have you had any trouble having an orgasm?
8. For women: Have you had pain during intercourse?
Have you had difficulty having an orgasm?
Have you had problems with lubrication?
9. Have you had any concerns about getting a sexual disease or AIDS?
10. Have you had any other questions or concerns about this subject?

Musculoskeletal ROS

Have you had any pain in your joints? Which ones?
Have you noticed any joint or muscle stiffness?
Have you had any joint swelling? (Which joint?)
Have you noticed any muscle weakness?
Have you had any muscle tenderness?
Have you had any back pains? (Upper back? Lower back?)

Neurologic ROS

Have you had any numbness (paresthesias)? Where?
Have you had any tingling (dysesthesias)? Where?
Have you had any problems with your memory?
Have you had any headaches? Where?
Have you noticed any dizziness (Vertigo)?
Have you had any problems with tremors (shaking)?
Have you had any episodes of blacking out (syncope) or loss of consciousness?
Have you had any problems with unsteadiness or balance?

PSYCHIATRIC ROS

Have you had any problems with anxiety?
Have you had any problems with depression?
Ask about symptoms of depression (**SIGECAPS**). Do you have any:
 difficulty getting to **Sleep** or waking up early (insomnia)?
 loss of **Interest** in doing things (anhedonia)?
 feelings of **Guilt**?
 lack of **Energy**, fatigue?
 problems with **Concentration**?
 loss of **Appetite** (anorexia) or increase in *appetite*?
 problems with slow thinking or moving (**Psychomotor** slowing)?
 thoughts of **Suicide**?
Have you seen people or things that others did not see? (Hallucinations)