Work*Star™

Occupational Health Systems

Review of Systems

Name: _____ **Date of Injury:** _____ **Today's Date:** _____

Please indicate if you have had any of these problems recently:

Constitutional:	YES	NO	**Cardiovascular:**	YES	NO
Headache	☐	☐	Chest pain or pressure	☐	☐
Tired all the time	☐	☐	Palpitations (heart feels jumpy)	☐	☐
Fever	☐	☐	Ankle swelling	☐	☐
Chills	☐	☐	**Genitourinary:**		
Weight loss or gain	☐	☐	Pain in the genitals	☐	☐
Eyes:			Pain when urinating	☐	☐
Pain in the eyes	☐	☐	Urinating too often	☐	☐
Redness of the eyes	☐	☐	Cannot urinate	☐	☐
Double vision	☐	☐	Cannot hold urine	☐	☐
Blurred vision	☐	☐	Pus or blood in urine	☐	☐
Partial blindness	☐	☐	**Neurological:**		
Ears:			Change of taste or smell	☐	☐
Pain in ears	☐	☐	Weakness or numbness	☐	☐
Hard of hearing	☐	☐	Tingling or pins and needles	☐	☐
Bleeding	☐	☐	Loss of ba1ance or dizziness	☐	☐
Nose:			Trouble with speech	☐	☐
Pain in nose	☐	☐	Trouble with swallowing	☐	☐
Change of taste or smell	☐	☐	**Psychiatric:**		
Runny nose or sinus trouble	☐	☐	Depression	☐	☐
Bleeding from the nose	☐	☐	Anxiety	☐	☐
Mouth:			Unusual fears or violent thoughts	☐	☐
Pain in the mouth	☐	☐	Don't want to eat	☐	☐
Sores in the mouth	☐	☐	No desire for sex	☐	☐
Bleeding in the mouth	☐	☐	Irritable or violent	☐	☐
Throat:			Bad temper or angry all the time	☐	☐
Pain in the throat	☐	☐	Forgetful or absent minded	☐	☐
Swallowing problems	☐	☐	**Skin:**		
Gastrointestinal:			Cuts, scrapes, bruses	☐	☐
Belly pain	☐	☐	Boils or rash	☐	☐
Heartburn	☐	☐	Rash from the sun	☐	☐
Nausea or Vomiting	☐	☐	**Sleep:**		
Bloating	☐	☐	Cannot get to sleep	☐	☐
Constipation	☐	☐	Cannot stay a sleep	☐	☐
No control of bowels	☐	☐	**Activities of daily living:**		
Endocrine:			Need help getting dressed	☐	☐
Diabetes	☐	☐	Need help using the toilet	☐	☐
Thyroid	☐	☐	Need help bathing	☐	☐
Respiratory	☐	☐	Need help brushing your teeth	☐	☐
Shortness of breath	☐	☐	Need help combing your hair	☐	☐
Wheezing	☐	☐	Need help counting money	☐	☐
Cough	☐	☐	Unable to drive	☐	☐

Your Signature: **Physician signature:**

Print Form