MEDICARE REVIEW OF SYSTEMS

Yes	No		Yes	No	
☐	☐	Smoking?	☐	☐	Wheezing?
☐	☐	Exposure to second hand smoke?	☐	☐	Chest Congestion?
☐	☐	Alcohol Use?	☐	☐	Cough?
☐	☐	Past Drug Use?	☐	☐	Coughing Up Blood?
☐	☐	Current Drug Use?	☐	☐	Chest Pain?
☐	☐	Living Alone?	☐	☐	Palpitations?
☐	☐	Living with?	☐	☐	Shortness of Breath?
☐	☐	Having Family Support?	☐	☐	Shortness of Breath with Exertion?
☐	☐	Having Pets?	☐	☐	Swelling?
☐	☐	Driving a Car?	☐	☐	Abdominal Pain?
☐	☐	Seat Belt Use?	☐	☐	Nausea?
☐	☐	Following Diet?	☐	☐	Vomiting?
☐	☐	Exercising?	☐	☐	Heartburn?
☐	☐	Financial Concerns?	☐	☐	Constipation?
☐	☐	Annual Influenza?	☐	☐	Diarrhea?
☐	☐	Hepatitis B?	☐	☐	Blood in Stools?
☐	☐	Pneumococcal Polysaccharide?	☐	☐	Incontinence?
☐	☐	Tetanus- Diphtheria- Pertussis?	☐	☐	Sexually Active?
☐	☐	Tetanus- Diphtheria- Toxoid?	☐	☐	Joint Pain?
☐	☐	Zostavax?	☐	☐	Muscle Pain?
☐	☐	Weight Changes?	☐	☐	Stiffness?
☐	☐	Fever?	☐	☐	Neck Pain?
☐	☐	Chills?	☐	☐	Back Pain?
☐	☐	Fatigue?	☐	☐	Difficulty Walking?
☐	☐	Vision Difficulties?	☐	☐	Bruising?
☐	☐	Hearing Difficulties?	☐	☐	Dryness?
☐	☐	Sinus/Nasal Congestion?	☐	☐	Headaches?
☐	☐	Mouth Problems?	☐	☐	Lightheadedness?
☐	☐	Difficulty Swallowing?	☐	☐	Dizziness When standing?
☐	☐	Hoarseness?	☐	☐	Weakness**?**

Yes	No	
☐	☐	Trouble Concentrating?
☐	☐	Memory Loss?
☐	☐	Anxiety?
☐	☐	Depression?
☐	☐	Stress?
☐	☐	Excessive Appetite?
☐	☐	Excessive Sweating?
☐	☐	Excessive Thirst?
☐	☐	Excessive Urination?
☐	☐	Heat Intolerance?
☐	☐	Cold Intolerance?
☐	☐	Hair Loss?
☐	☐	Bleeding?
☐	☐	Anemia?
☐	☐	Swollen Glands?
☐	☐	Environmental Allergies?
☐	☐	Immunodeficiency?
☐	☐	Bathing Self?
☐	☐	Dressing Self?
☐	☐	Grooming Self?
☐	☐	Feeding Self w/o Assistance?
☐	☐	Toileting Independently?
☐	☐	Maintaining Continence?
☐	☐	Transferring Independently?
☐	☐	Drives Car Independently?
☐	☐	Uses Public Transportation Independently?
☐	☐	Shops Independently?
☐	☐	Ability to Use Telephone?
☐	☐	Maintains House Independently?
☐	☐	Handles own Finances?
☐	☐	Has assistive Devices in the bathroom?
☐	☐	Has loose thrown runs in home?

Yes	No	
☐	☐	Had obstacles in walking path?
☐	☐	Has difficulty transferring?
☐	☐	Poor Vision and Bifocals?
☐	☐	Has fallen before?
☐	☐	Has trouble holding?
☐	☐	Has low vitamin D levels?
☐	☐	Has poor balance?
☐	☐	Has muscle weakness?
☐	☐	Has a fear of falling?
☐	☐	Small rugs are tacked down or non-skid?
☐	☐	Flooring & Steps are in good repair?
☐	☐	Steps have non-skid surfaces?
☐	☐	Wears shoes or non-skid socks inside?
☐	☐	Exits, halls, stairways and pathways are clear & well lit?
☐	☐	Interior stairs have secure handrails?
☐	☐	Exterior stairs are in good repair & have Handrails?
☐	☐	Has working telephone?
☐	☐	Is aware of life line?
☐	☐	Uses sturdy step stool with handrails?
☐	☐	Bath tub & shower are equipped with grab bars & non-skid surface?
☐	☐	Uses shower chair?
☐	☐	Has no difficulty getting off toilet?
☐	☐	Canes, walker & wheelchair are in good Repair?
☐	☐	Bed is at the proper height?
☐	☐	Smoke detectors are present & checked twice per year?
☐	☐	Has fire extinguisher available?
☐	☐	Ability to manage thermostat?
☐	☐	Has ability to verbalize & enact emergency plan?