Obesity-Focused Review of Systems

Date _____

Patient Name

Last _____ First _____ Middle Initial ____

Age _____ Sex Male _____ Female _____ Other _____

Endocrine	**Yes**	**No**
Do you have type 1 diabetes?	☐	☐
Do you have type 2 diabetes?	☐	☐
Have you been told that you have prediabetes?	☐	☐
Do you have a history of hyperthyroidism (overactive thyroid)?	☐	☐
Do you have history of hypothyroidism (underactive thyroid)?	☐	☐
Have you or anyone in your family had medullary thyroid cancer?	☐	☐
Do you have dry mouth?	☐	☐
Do you have excessive urination?	☐	☐
Do you have excessive thirst?	☐	☐
Women		
Do you have increased facial hair?	☐	☐
Do you have acne?	☐	☐
Do you have irregular periods?	☐	☐
Have you been diagnosed with infertility or been told you're infertile?	☐	☐
Men		
Have you been diagnosed with low testosterone (low-T)?	☐	☐
Do you have low sex drive?	☐	☐

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Endocrine	Yes	No
Have you been diagnosed with erectile dysfunction?	☐	☐

Lung and Breathing Disorders	Yes	No
Do you have a history of asthma?	☐	☐
Do you have a history of COPD (chronic obstructive pulmonary disease)?	☐	☐
Do you snore?	☐	☐
Have you been diagnosed with sleep apnea (severe snoring that interferes with your sleep)?	☐	☐
Do you wheeze?	☐	☐
Do you get short of breath when walking?	☐	☐

Cardiac	Yes	No
Have you ever been diagnosed with angina?	☐	☐
Have you ever had a heart attack?	☐	☐
Have you ever been diagnosed with congestive heart failure (CHF)?	☐	☐
Have you been diagnosed with heart valve disease?	☐	☐
Do you get short of breath when laying down?	☐	☐
Do your feet swell?	☐	☐
Have you ever been diagnosed with an arrhythmia (irregular heart beat)?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Do you take medication for high cholesterol?	☐	☐
Do you take medication for high blood pressure?	☐	☐
Do you ever have chest pain?	☐	☐

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Cardiac	Yes	No
Do you ever have palpitations (racing heart)?	☐	☐

Urinary	Yes	No
Do you have a history of kidney stones?	☐	☐
Do you have trouble holding your urine?	☐	☐
Do you experience excessive urination (urinate more than normal)?	☐	☐
At night, do you wake up to urinate?	☐	☐
Do you ever have blood in your urine?	☐	☐

Eye	Yes	No
Do you have a history of glaucoma?	☐	☐
Do you have diabetic retinopathy (diabetes-related eye disease)?	☐	☐
Do you have blurry vision?	☐	☐

Gastrointestinal	Yes	No
Have you ever been diagnosed with GERD (gastroesophageal reflux disease)?	☐	☐
Do you ever have heartburn?	☐	☐
Have you ever been diagnosed with liver disease? What type(s): _____ _____	☐	☐
Have you had gallstones?	☐	☐
Have you had your gallbladder removed?	☐	☐
Have you ever been diagnosed with pancreatitis?	☐	☐

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Gastrointestinal	Yes	No
Do you have abdominal pain?	☐	☐
Have you had part of your intestine removed?	☐	☐
Have you been diagnosed with gastroparesis?	☐	☐
Do you frequently have diarrhea?	☐	☐
Do you frequently have nausea?	☐	☐
Do you vomit frequently?	☐	☐

Psychiatric	Yes	No
Have you ever been diagnosed with depression?	☐	☐
Have you ever been diagnosed with anxiety?	☐	☐
Have you ever taken medication for depression or anxiety?	☐	☐
Have you ever been diagnosed with ADHD (attention deficit hyperactivity disorder)?	☐	☐
Have you ever been diagnosed with bipolar disorder?	☐	☐
Do you have trouble sleeping?	☐	☐
Do you have memory loss?	☐	☐
Do you avoid social interaction because of your weight?	☐	☐
Have you ever felt discriminated against because of your weight?	☐	☐
Does being overweight cause you to feel depressed?	☐	☐
Do you drink more than 2 alcoholic beverages per day?	☐	☐
Do you take pain medication or opiates on a regular basis?	☐	☐

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Oncology	Yes	No
Have you ever been diagnosed with cancer? What type(s): _____ _____	☐	☐
Have you ever had a colonoscopy? When was the last time: _____	☐	☐
Women Have you ever had a mammogram? When was the last time: _____	☐	☐

Obstetrics	Yes	No
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you planning to become pregnant within the next year?	☐	☐
Have you ever had trouble getting pregnant or used fertility treatments?	☐	☐

Neurologic	Yes	No
Have you ever had a seizure	☐	☐
Have you ever had a stroke?	☐	☐
Do you have tingling in your fingers or feet?	☐	☐
Do you have a hand tremor, or does your hand shake when you hold it out?	☐	☐
Have you ever had migraine headaches?	☐	☐
Do you take medication to prevent migraines?	☐	☐

Nephrology	Yes	No
Have you been diagnosed with chronic kidney disease (CKD) or diabetic nephropathy?	☐	☐

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Joint Diseases	Yes	No
Do you have a history of arthritis?	☐	☐
Do you have pain in your knees?	☐	☐
Do you have pain in your hips?	☐	☐
Do you have chronic back pain?	☐	☐
Do you have trouble walking or exercising due to joint pain?	☐	☐
Do you take medication for joint or back pain?	☐	☐
Have you had a joint replacement (e.g., hip or knee surgery)?	☐	☐