VCU CENTER FOR SLEEP MEDICINE

REVIEW OF SYSTEMS QUESTIONNAIRE

Name:_____
DOB:_____
MR#:_____

Are you currently having any of the following problems? *Check all that apply* ☑

Constitution:
☐ Fever ☐ Chills ☐ Weight Loss
☐ Weight Gain

Eyes:
☐ Blurred/Double Vision ☐ Floaters
☐ Eye pain

Ears, Nose, Throat:
☐ Hearing Loss ☐ Ringing ☐ Congestion
☐ Imbalance ☐ Difficulty Swallowing

Cardiovascular
☐ Chest Pain ☐ Irregular Beats
☐ Swelling in Legs

Respiratory:
☐ Coughing ☐ Wheezing
☐ Short of Breath

Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Heartburn
☐ Constipation ☐ Diarrhea
☐ Stomach Pain ☐ Blood in Stool

Endocrine:
☐ Excessive Thirst ☐ Sweating
☐ Too hot/cold

Genitourinary:
☐ Overnight Urination ☐ Incontinence
☐ Painful Urination ☐ Urinary Frequency
☐ Bleeding with Urination ☐ Decrease Sex Drive
☐ Impotence ☐ Menstrual Problems

Musculoskeletal:
☐ Pain in Muscles/Joints ☐ Swelling
☐ Weakness ☐ Recent falls
☐ Leg Movements Before/During Sleep

Skin:
☐ Rash/Hives ☐ Pain ☐ Itching

Neurologic:
☐ Numbness/Tingling ☐ Headache ☐ Dizziness
☐ Seizure ☐ Loss of Consciousness

Psychological:
☐ Mood Problems ☐ Depression ☐ Anxiety
☐ Increased Life Stressors ☐ Crying Spells
☐ Thoughts of Suicide

Lymph/Heme:
☐ Seasonal Allergies ☐ Food Allergies
☐ Bleeding/Bruising Problems

How sleepy have you been over the last 4 weeks?

Situation	Chance of Dozing or Sleeping (circle the most appropriate number) Low			High
Sitting and reading ……	0	1	2	3
Watching TV……	0	1	2	3
Sitting inactive in a public place……	0	1	2	3
Being a passenger in a motor vehicle for an hour or more..	0	1	2	3
Lying down in the afternoon……..	0	1	2	3
Sitting and talking to someone……	0	1	2	3
Sitting quietly after lunch (no alcohol)……..	0	1	2	3
Stopped for a few minutes in traffic while driving……	0	1	2	3

Total Score (add up the circled numbers)……. _____