

# PASRR/Review of Systems

Client Name: \_\_\_\_\_

As indicated by staff, chart review, physical examination and/or individual's report, please specify whether the individual is experiencing problems in the following categories.

**1. Neurological Problems**  No If Yes, please specify:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Traumatic brain injury      | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Tremors                     | <input type="checkbox"/> Unsteady balance/gait |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Blackouts            | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Tardive Dyskinesia    |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> Paresthesia          | <input type="checkbox"/> Seizures (last occurrence): | _____  |

Other/Comments: \_\_\_\_\_

**2. Vision Problems**  No If Yes, please specify:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Field cut      | <input type="checkbox"/> Lights/spots        | <input type="checkbox"/> Corrected with glasses |
| <input type="checkbox"/> Vision loss    | <input type="checkbox"/> Unequal pupils | <input type="checkbox"/> Reading small print |   |

Other/Comments: \_\_\_\_\_

**3. Hearing problems**  No If Yes, please specify:

- |   |  |   |                                       |  |
|---|--|---|---------------------------------------|--|
| <input type="checkbox"/> Hearing others | <input type="checkbox"/> Hearing in groups | <input type="checkbox"/> Hearing whispers | <input type="checkbox"/> Pain in ears | <input type="checkbox"/> Correct with aid/device |
|---|--|---|---------------------------------------|--|

Other/Comments: \_\_\_\_\_

**4. Nose problems**  No If Yes, please specify:

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Frequent runny nose | <input type="checkbox"/> Decreased ability to smell | <input type="checkbox"/> Nose bleeds |
|---|--|---|--------------------------------------|

Other/Comments: \_\_\_\_\_

**5. Mouth problems**  No If Yes, please specify:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Sore/bleeding gums | <input type="checkbox"/> Loose teeth               | <input type="checkbox"/> Tooth decay   |
| <input type="checkbox"/> Dry mouth          | <input type="checkbox"/> Corrected with aid/device | <input type="checkbox"/> Teeth missing |

Other/Comments: \_\_\_\_\_

**6. Throat/Neck problems**  No If Yes, please specify:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Choking episodes | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Lump in throat |
|--|---|--|---|

Other/Comments: \_\_\_\_\_

**7. Cardiovascular problems**  No If Yes, please specify:

- |   |  |   |   |   |       |
|---|--|---|---|---|-------|
| <input type="checkbox"/> Pain on exertion | <input type="checkbox"/> Non-exertional pain | <input type="checkbox"/> Irregular beat | <input type="checkbox"/> CHF                  | <input type="checkbox"/> Bypass (date): | _____ |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Hypotension         | <input type="checkbox"/> ASHD           | <input type="checkbox"/> Previous CVA (date): |   | _____ |

Other/Comments: \_\_\_\_\_

**8. Circulatory problems**  No If Yes, please specify:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Night calf pain | <input type="checkbox"/> Pain when walking        | <input type="checkbox"/> Ulcers on lower leg |
| <input type="checkbox"/> Varicose veins  | <input type="checkbox"/> Pedal pulses not present | <input type="checkbox"/> Edema of legs/feet  |

Other/Comments: \_\_\_\_\_

