

Patient Name: _____

Birth date: ____/____/____

Review of Systems

Please **check (X)** if any of the following applies to you now.

CONSTITUTIONAL

- Weight loss
- Weight Gain
- Fever
- Fatigue
- Night Sweats
- Hot Flashes

EYES

- Double Vision
- Vision changes

HEENT

- Headaches
- Dizziness
- Sore throat
- Sinus
- Pain
- Nose Bleeding
- Thyroid Mass
- Neck Pain

BREAST

- Lumps
- Tenderness
- Swelling
- Nipple Discharge
- Pain

CARDIOVASCULAR

- Chest Pain
- Irregular Heart Beat
- Rapid Heart Beat
- Fainting
- Swelling of the legs
- Varicose Veins

RESPIRATORY

- Wheezing
- Cough
- Shortness of Breath
- Coughing blood

GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal Pain
- Bloody/black Stools
- Hemorrhoids
- Jaundice

GENITOURINARY

- Urgency of urination
- Frequency of urination

NOTES

GENITOURINARY (cont.)

- Pain with urination
- Incontinence
- Blood in urine
- Pain with intercourse
- Possible pregnancy
- Genital sores
- Vaginal discharge

SKIN

- Rashes
- Itching
- Dryness
- Lesions
- Changes in lesions
- Acne

NEUROLOGICAL

- Muscular weakness
- Numbness/Tingling
- Difficulty Concentrating
- Memory Difficulties
- Speech Difficulties
- Seizures
- Loss of Balance

MUSCULOSKELETAL

- Joint pain
- Muscle Pain
- Back Pain

ENDOCRINE

- Hair Loss
- Intolerance to Heat
- Intolerance to Cold

PSYCHIATRIC

- Anxiety
- Depression
- Impulsive behavior
- Suicidal thoughts
- Mood swings
- Physical abuse
- Substance abuse

HEMATOLOGIC/LYMPHATIC

- Frequent or easy bruising
- Excessive bleeding
- Enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC

- Frequent illness
- Seasonal allergies

OTHER

NOTES

