Review of Systems

Name:________________________________ DOB:________________ Today's Date:____________

Please place a check mark beside any of the following symptoms or problems if you have experienced them recently or have concerns about them.

A. General:
- ____ Fevers, chills, or sweats
- ____ Recent loss of appetite
- ____ Fatigue
- ____ Recent unexpected weight loss

B. Eyes:
- ____ Blurred or double vision
- ____ Eye pain or irritation
- ____ Eye discharge

C. Ears, Nose, Throat:
- ____ Earache
- ____ Ringing in ears
- ____ Decreased hearing
- ____ Difficulty swallowing
- ____ Frequent nose bleeds
- ____ Prolonged hoarseness
- ____ Sinus trouble or congestion

D. Cardiovascular:
- ____ Chest pain
- ____ Fainting spells
- ____ Palpitation
- ____ Shortness of breath with exertion
- ____ Swollen ankles

E. Respiratory:
- ____ Chronic cough
- ____ Chronic wheezing
- ____ Coughing up blood
- ____ Excessive Phlegm

F. Gastrointestinal:
- ____ Persistent nausea/vomiting
- ____ Diarrhea
- ____ Constipation
- ____ Change in appearance of stool
- ____ Chronic abdominal pain
- ____ Bloody or very black stool
- ____ Jaundice (yellow skin)

G. For women:
- ____ Unusual vaginal discharge
- ____ Loss of control of your urine
- ____ Painful urination
- ____ Blood in urine
- ____ Increased frequency of urination
- ____ Stopped periods
- ____ Nipple discharge
- ____ Breast mass or tenderness

H. For men:
- ____ Painful urination
- ____ Blood in urine
- ____ Increased frequency of urination
- ____ Urination more than twice a night
- ____ Loss of control of your urine
- ____ Difficulty getting or maintaining an erection

I. Musculoskeletal:
- ____ Back pain
- ____ Joint pain
- ____ Swelling in joints

Name: ________________________________ Date: _____ / _______ / _________

J. Skin:

- ____ Skin rashes
- ____ Itching
- ____ Chronic dry skin
- ____ Suspicious moles or other skin abnormalities you are concerned about

K. Neurologic:

- ____ Headache
- ____ Weakness
- ____ Numbness/tingling sensations
- ____ Seizures/convulsions
- ____ Fainting spells
- ____ Tremor/hand shaking
- ____ Dizziness/vertigo

L. Psychological:

- ____ Feeling depressed or sad
- ____ Memory loss

M. Endocrine:

- ____ Cold or heat intolerance
- ____ Significant weight change

N. Heme and Lymphatic:

- ____ Excessive bruising or bleeding
- ____ Swollen glands in neck, armpits, or groin

Smoking History:

____ Smoking - How much?

____ Alcohol - How much?

Family History:

	Age	Alive?	Cause of Death	Medical Problems
Father:				
Mother:				
Siblings:				
Children:				