Review of Systems

Patient Name:_____ Acct.#_____ Date_____

Please check ALL symptoms you have recently experienced:

I. HEENT - ☐ double vision
☐ blurred vision
☐ ringing in the ears
☐dizzy
☐ poor hearing
☐severe headache
☐severe recurrent nose bleed
☐difficulty swallowing

II. CARDIOPULMONARY
☐dull chest pain
☐pressure/tightness
☐chest palpitations (fluttering)
☐shortness of breath at rest
☐shortness of breath with exertion
☐shortness of breath when lying flat
☐coughing
☐coughing up blood
☐swelling feet
☐severe sweating at night

III. GASTROINTESTINAL
☐abdominal pain
☐vomiting
☐vomiting blood
☐black & tarry stool
☐ bloody stools
☐clay colored stools
☐loss of bowel control
☐dramatic change in bowel habits
☐jaundice(yellowing of skin, eyes)

IV. GENITOURINARY
☐burning on urination
☐blood in urine
☐urinary frequency
☐loss of bladder control
☐penile or vaginal discharge
☐penile or vaginal bleeding
☐genital sores

V. MUSCULOSKELETAL
☐joint pain
☐ joint swelling
☐grinding of joints
☐locking of joints
☐ neck pain
☐ back pain

VI. CONSTITUTIONAL
☐fever
☐chills
☐night sweats
☐loss of appetite
☐unintentional weight loss

VII. CNS
☐paralysis in arms or legs
☐numbness in arms or legs
☐ loss of consciousness
☐seizures
☐tremors
☐jerking
☐poor coordination

VIII. SKIN
☐loss of hair
☐dry sores_____location
☐itchiness
☐rashes

IX. ENDOCRINE
☐increase thirst
☐excessive urination
☐excessive drinking
☐hot/cold intolerance
☐excessive sweating

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Patient Signature