

REVIEW OF SYSTEMS

NAME _____

Date _____

CONSTITUTIONAL YES NO

Weight Loss/Gain _____
Fatigue _____
Fever _____
Sweats _____

EYES

Glasses/Contacts _____
Pain _____
Double Vision _____
Blind Spots _____
Blind _____
Cataracts _____
Glaucoma _____

EAR/NOSE/THROAT

Hearing Loss _____
Ringing In Ears _____
Ear Pain _____
Vertigo _____
Nasal Stuffiness _____
Sinus Troubles _____
Sore Throat _____
Difficulty Swallowing _____
Hoarseness _____

CARDIOVASCULAR

Chest Pains _____
Heart Attack _____
Palpitations _____
Murmur _____
High Blood Pressure _____
Dizziness _____
Fainting Spells _____
Difficulty Lying Flat _____
Swollen Ankles _____

RESPIRATORY

Cough _____
Cough Blood _____
Shortness of Breath
 At Rest _____
 With Exertion _____
Wheezing _____

GASTROINTESTINAL

Nausea/Vomiting _____
Difficulty Swallowing _____
Abdominal Pain _____
Jaundice _____
Diarrhea _____
Constipation _____
Change in BM's _____
Pain with BM's _____
Rectal Bleeding _____

GENITOURINARY YES NO

Urgency _____
Frequency _____
Nighttime Frequency _____
Burning _____
Blood in urine _____
Decreased Stream _____
Kidney Stones _____
Sexually Transmitted Disease _____
Abnormal Discharge _____

HEME/LYMPH

Easy Bruising _____
Bleeding Gums _____
Enlarged Glands _____
Blood Transfusion _____

MUSCULOSKELETAL

Joint Pain/Swelling _____
Stiffness _____
Muscle Pain _____
Neck/Back Pain _____

SKIN

Rash/Sores _____
Lesions _____
Itching/Burning _____

NEUROLOGICAL

Headaches _____
Seizures _____
Tremors _____
Weakness/Paralysis _____
Numbness/Tingling _____
Speech Difficulty _____
Memory Loss _____

ENDOCRINE

Hair Loss _____
Heat/Cold Intolerance _____
Change in Nails _____
Thyroid problems _____
Diabetes _____
Blood sugar problems _____

ALLERGIC/IMMUNE

Hay Fever / Asthma _____
Eczema/Hives _____

PYCHIATRIC

Anxiety/Depression _____
Mood Swings _____
Difficulty Sleeping _____