

# REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_

## Constitutional Systems

	YES	NO
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>

## Skin

Rashes or color changes	<input type="checkbox"/>	<input type="checkbox"/>
Itching or dryness	<input type="checkbox"/>	<input type="checkbox"/>
Hair or nail changes	<input type="checkbox"/>	<input type="checkbox"/>
Changing Moles	<input type="checkbox"/>	<input type="checkbox"/>

## Eyes

Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision or haloes	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>

## Ears, Nose, Mouth, Throat

Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Ringing or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose / post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Dryness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>

## Cardiovascular

Chest pains or palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

## Respiratory

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

## Endocrine

Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or hunger	<input type="checkbox"/>	<input type="checkbox"/>

## Gastrointestinal

	Yes	NO
Swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>

## Genito-urinary

Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Urinary pain or blood	<input type="checkbox"/>	<input type="checkbox"/>

### Males:

Discharge, lesions or masses	<input type="checkbox"/>	<input type="checkbox"/>
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### Females:

Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Breast masses or discharge	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding / discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>

## Musculoskeletal

Joint pain, swelling, redness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>

## Neurological

Headaches/ migraines	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Slurred speech	<input type="checkbox"/>	<input type="checkbox"/>

## Psychiatric

Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

## Hematological/Lymphatics/Immunology

Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER SYMPTOMS NOT LISTED ABOVE:**

DATE \_\_\_\_\_

Reviewed by: Dr. Darnell Martin-Wimmer