PRINT NAME:_____

REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS YOU ARE EXPERIENCING:

GENERAL
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

SKIN
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

EAR, NOSE, THROAT
- ☐ Nasal congestion
- ☐ Post-nasal drip
- ☐ Sore throat
- ☐ Earache
- ☐ Nose Bleed

CARDIAC/PULMONARY
- ☐ Chest pain or discomfort
- ☐ Coughing/wheezing
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling in hands or feet
- ☐ Change in appetite

GASTROINTESTINAL
- ☐ Swallowing difficulties
- ☐ Heart burn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea

VASCULAR
- ☐ Calf pain with walking
- ☐ Leg cramping

MUSCULOSKELETAL
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

NEUROLOGICAL
- ☐ Dizziness
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

HEMATOLOGIC
- ☐Ease of bruising
- ☐Ease of bleeding

ENDOCRINE
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst

PSYCHIATRIC
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

PATIENT SIGNATURE: _____ **DATE:**_____

PHYSICIAN SIGNATURE: _____ **DATE:**_____