REVIEW OF SYSTEMS 1 of 2 Name: ______________________________

PLEASE Bubble in ONLY 1 answer per question. EXAMPLE of how to fill out bubble - O ●Yes O No

Mark YES only if the problem or symptom is CURRENT

General

Fever	O Yes	O No	Change in Weight	O Yes	O No
Fatigue	O Yes	O No	Change in Appetite	O Yes	O No
Sweats	O Yes	O No			

Head, Eyes, Ears, Nose, Throat

Vision Changes	O Yes	O No	Bad Taste or Bad Breath	O Yes	O No
Glasses and/or Contacts	O Yes	O No	Hoarseness / Voice Changes	O Yes	O No
Allergies / Sinus Problems	O Yes	O No	Mouth Sores	O Yes	O No
Hearing Loss/Ringing	O Yes	O No	Snoring	O Yes	O No
Cold Symptoms	O Yes	O No	Swollen Glands	O Yes	O No
Difficulty Swallowing	O Yes	O No	Teeth Pain	O Yes	O No
Nosebleeds	O Yes	O No			

Cardiovascular

Chest pain	O Yes	O No	Pain in legs while walking	O Yes	O No
Irreg Heart Beat /Palpitations	O Yes	O No	Short or breath when lying	O Yes	O No
Lower extremity swelling	O Yes	O No	Difficulty walking up stairs	O Yes	O No

Respiratory

Blood Tinged Sputum	O Yes	O No	Pain w/ Breathing	O Yes	O No
Chest Congestion	O Yes	O No	Shortness of Breath	O Yes	O No
Chronic/ Frequent Cough	O Yes	O No	Wheezing	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No	Constipation	O Yes	O No
Heartburn	O Yes	O No	Diarrhea	O Yes	O No
Bloating	O Yes	O No	Hemorrhoids	O Yes	O No
Rectal Bleed / Blood in Stool	O Yes	O No	Nausea / Vomiting	O Yes	O No
Change in Bowel Habits	O Yes	O No			

Male Reproductive

Sexual Difficulty	O Yes	O No
Hernia	O Yes	O No
Testicular Pain / Swelling	O Yes	O No

Female Reproductive

Abn Vaginal Discharge	O Yes	O No	Hot Flashes	O Yes	O No
Breast Lumps/Discharge	O Yes	O No	Irregular Menses	O Yes	O No
Breast Tenderness	O Yes	O No	Still Menstruating	O Yes	O No
Sexual Difficulty	O Yes	O No	Contraception	O Yes	O No
Heavy Periods	O Yes	O No			

Musculoskeletal

Joint Pain	O Yes	O No
Joint Stiffness	O Yes	O No
Joint Swelling	O Yes	O No
Muscle Aches/ Weakness	O Yes	O No

Skin

Healing Problems	O Yes	O No
Changing Moles	O Yes	O No
Rash / Itching	O Yes	O No
Change in hair/ nails	O Yes	O No
Varicose Veins	O Yes	O No

Neurology

Confusion	O Yes	O No	Tremor	O Yes	O No
Dizziness/ Fainting	O Yes	O No	Trouble w/ Balance	O Yes	O No
Memory Loss	O Yes	O No	Weakness	O Yes	O No
Restless Leg Symptoms	O Yes	O No	Seizures	O Yes	O No
Tingling / Numbness	O Yes	O No	Frequent Headaches	O Yes	O No

Psychology

Anxiety / Panic Attacks	O Yes	O No
Depression	O Yes	O No
Trouble Sleeping	O Yes	O No
Suicidal Thoughts	O Yes	O No

Endocrinology

Excessive Sweating	O Yes	O No
Excessive Thirst / Urination	O Yes	O No
Heat or Cold Intolerance	O Yes	O No
Skin Changes	O Yes	O No

Hematology/Lymph

Easy Bleeding	O Yes	O No	Swollen Glands	O Yes	O No
Easy Bruising	O Yes	O No			

Urology

Blood in Urine	O Yes	O No	Urinary Frequency	O Yes	O No
Pain w/ Urination	O Yes	O No	Urinary Incontinence	O Yes	O No

Please list any **NEW** DRUG, FOOD or NON-FOOD Allergies that you have developed **in the last year**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please list any SURGERIES, MAJOR PROCEDURES, HOSPITALIZATIONS or INJURIES **in the last year**

____________________ ____________________ ____________________

____________________ ____________________ ____________________