Review of Systems

Date _____ Name _____

	Yes	No
CARDIOVASCULAR		
Chest Pains		
Difficulty Lying Flat		
Dizziness		
Fainting		
Fatigue		
Heart Attack		
Heart Murmur		
High Blood Pressure		
Shortness of Breath at Rest		
Shortness of Breath w/Exertion		
Swelling of Feet/Ankles/Hands		
Palpitations		
CONSTITUTIONAL		
Fever		
Weight Gain		
Weight Loss		
Sweats		
EAR/NOSE/THROAT		
Hearing Loss		
Ear Pain		
Hoarseness		
Nasal Stuffiness		
Ringing in Ears		
Sinus Troubles		
Sore Throat/Voice Change		
Swallowing Difficulty		
Vertigo		
ENDOCRINE		
Heat/Cold Intolerance		
Blood Sugar Problems		
Diabetes		
Hair Loss		
Headaches		
Nail Changes		
Thyroid Problems		
EYES		
Blind		
Blind Spots		
Cataracts		
Contacts		
Double Vision		
Glasses		
Glaucoma		
Pain		
PSYCHOLOGICAL		
Memory Loss		
Anxiety/Depression		
Mood Swings		
Difficulty Sleeping		

	Yes	No
GASTROINTESTINAL		
Abdominal Pain		
Change in BM's		
Diarrhea		
Jaundice		
Nausea		
Pain with BM's		
Rectal Bleeding		
Vomiting		
Constipation		
GENITOURINARY		
Bloody Urine		
Burning or Painful Urination		
Decreased Stream		
Discharge		
Frequent Urination		
Kidney Stones		
Urination at Night		
Sexually Transmitted Disease		
IMMUNE/LYMPH		
Bleeding Gums		
Blood Transfusion		
Easy Bruising		
Enlarged Glands		
Hay Fever/Asthma		
Eczema/Hives		
MUSCULOSKELETAL		
Back/Neck Pain		
Muscular Pain		
Stiffness		
Joint Pain/Swelling		
NEUROLOGICAL		
Clear Speech		
Convulsions or Seizures		
Numbness/Tingling		
Weakness/Paralysis		
Tremors		
RESPIRATORY		
Cough		
Wheezing		
Cough Blood		
SKIN		
Itching/Burning		
Rash/Sores		
Lesions		