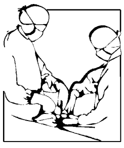

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REVIEW OF SYSTEMS/SYMPTOMS

PATIENT NAME ______________________________ DATE ______________

INSTRUCTIONS: PLEASE CHECK SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS.

GENERAL
_____ FATIGUE
_____ FEVER
_____ DECREASED APPETITE
_____ NIGHT SWEATS
_____ CHANGE IN WEIGHT

HEENT
_____ BLURRY VISION
_____ HEARING LOSS
_____ HOARSENESS
_____ LUMP/SWELLING IN NECK
_____ SORE THROAT
_____ WEARING GLASSES/ CONTACTS
_____ DENTURES

PULMONARY
_____ COUGH
_____ SHORTNESS OF BREATH
_____ WHEEZING
_____ COUGHING UP BLOOD

CARDIOVASCULAR
_____ CHEST PAIN
_____ ANKLE SWELLING
_____ PALPITATIONS
_____ SHORT OF BREATH IF LYING FLAT
_____ LEGS CRAMP/TIRE WHEN WALKING
_____ VARICOSE VEINS
_____ BLOOD CLOT IN VEINS

GENITOURINARY
_____ FREQUENT URINATION
_____ HESITANCY
_____ URGENCY
_____ INCONTINENCE
_____ PAINFUL URINATION
_____ BLOOD IN URINE
_____ IMPOTENCE

MUSCULOSKELETAL
_____ BACK PAIN
_____ BONE/JOINT PAIN
_____ NORMAL MOTION OF ALL EXTREMITIES

GASTROINTESTINAL
_____ DIFFICULTY SWALLOWING
_____ HEARTBURN
_____ NAUSEA
_____ VOMITING
_____ ABDOMINAL PAIN
_____ DIARRHEA
_____ CONSTIPATION
_____ BLACK STOOLS
_____ BLOOD IN STOOL
_____ ANAL PAIN

FEMALE
_____ BREAST MASS
_____ NIPPLE DISCHARGE
_____ PERIODS ABNORMAL
_____ DATE OF LAST PERIOD

SKIN
_____ SKIN LESIONS
_____ RASH
_____ YELLOW SKIN OR EYES
_____ CHANGING MOLE

NEUROLOGICAL
_____ HEADACHE
_____ TREMOR
_____ MEMORY PROBLEM
_____ SEIZURES

PSYCHIATRIC
_____ ANXIETY
_____ DEPRESSED
_____ OTHER MENTAL ISSUES

ENDOCRINE
_____ INTOLERANCE TO HOT OR COLD (PLEASE CIRCLE)
_____ EXCESSIVE THIRST

HEME/LYMPH
_____ EASY BRUISING
_____ EASY BLEEDING
_____ SWOLLEN NECK GLANDS
_____ SWOLLEN GROIN LYMPH NODES

ANYTHING ELSE? ____

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