REVIEW OF SYSTEMS

Name (First, MI, Last):		Date:	Date of Birth:
PLACE AN X IN ANY BOX NEXT TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR			
CONSTITUTION	☐ Recent weight changes	☐ Changes in appetite	☐ Persistent fever
☐ Night sweat-hot flashes	☐ Heat or cold sensitivity	☐ Tire easily	☐ Weakness or paralysis
SKIN/HAIR/NAILS	☐ Skin rash	☐ Dry skin	☐ Change in hair or nails	☐ Excessive perspiration
☐ Skin itching	☐ Wounds		
EYES	☐ Eye pain	☐ Eye redness	☐ Blurred / double vision	☐ Glasses or contacts
☐ Infected eyes			
EARS	☐ Ringing in the ears	☐ Discharge from ears	☐ Ear pain	☐ Decrease in hearing
NOSE	☐ Frequent nose bleeds	☐ Stuffiness / discharge	☐ Loss/lack of smell
MOUTH	☐ Sore tongue or gums	☐ Bleeding gums	☐ Persistent hoarseness
NECK	☐ Neck swelling	☐ Neck stiffness	☐ Sore throat
CHEST	☐ Frequent cough	☐ Wheezing	☐ Shortness of breath
☐ Bloody sputum	☐ Painful breathing	☐ Chest pain/discomfort	
HEART	☐ Swelling of hands/feet	☐ Palpitations	☐ Leg cramp on walking
☐ Heartburn	☐ Enlarged veins		
STOMACH/BOWELS	☐ Abdominal cramping	☐ Nausea/Vomiting	☐ Chronic diarrhea
☐ Chronic constipation	☐ Rectal bleeding	☐ Black tarry stools	
URINARY TRACT	☐ Frequent urination	☐ Increase in thirst	☐ Painful urination
☐ Leakage of urine	☐ Blood in urine		
GENITAL	☐ Lack of sex drive	☐ Painful sex	
NEURO	☐ Numbness/tingling	☐ Tremor	☐ Headaches
☐ Memory loss	☐ Sleep changes	☐ Depressed mood	
MUSCLES	☐ Backaches	☐ Joint pain or stiffness	☐ Swollen joints
☐ Muscle cramps/spasms			
MEN ONLY	☐ Difficulty with erection	☐ Testicle lump/pain	☐ Penis discharge
WOMEN ONLY	☐ Period absent	☐ Days between period	☐ Heavy flow
☐ Menstrual pain/cramps	☐ Bloody discharge	☐ Other discharge	☐ Breast lump/discharge
☐ Breast pain	Date last mammogram:______________	# Pregnancies: ________	# Living births: ________

Is there anything else you would like your doctor to know?

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