NAME: _____ DOB: _____

# REVIEW OF SYSTEMS

**NOTES**

| GENERAL CONSTITUTIONAL | | |
|---|---|---|
| Recent weight loss | No | Yes |
| Fever | No | Yes |
| Chills | No | Yes |

| EYES/VISION | | |
|---|---|---|
| Vision changes | No | Yes |

| EARS, NOSE, & THROAT | | |
|---|---|---|
| Hearing loss | No | Yes |

| HEART/CARDIOVASCULAR | | |
|---|---|---|
| Chest pain or pressure | No | Yes |
| Arrythmia or palpitations | No | Yes |
| Shortness of breath | No | Yes |
| Peripheral edema | No | Yes |
| Blood clots | No | Yes |
| Varicose veins | No | Yes |
| Cramping in thighs | No | Yes |

| RESPIRATORY | | |
|---|---|---|
| Cough | No | Yes |
| Shortness of breath | No | Yes |
| Wheezing | No | Yes |

| GASTROINTESTINAL | | |
|---|---|---|
| Abdominal pain | No | Yes |
| Heartburn | No | Yes |
| Bloody stool | No | Yes |

| GENITOURINARY | | |
|---|---|---|
| Frequent urination | No | Yes |

NAME: _____ DOB: _____

| | | |
|---|---|---|
| Urgency | No | Yes |

| **MUSCULOSKELETAL** | | |
|---|---|---|
| Joint pain or swelling | No | Yes |
| Restricted motion | No | Yes |
| Musculoskeletal pain | No | Yes |

| **SKIN & INTEGUMENTARY** | | |
|---|---|---|
| Rashes | No | Yes |
| Sores | No | Yes |
| Blisters | No | Yes |
| Growths | No | Yes |

| **NEUROLOGICAL** | | |
|---|---|---|
| Numbness or tingling | No | Yes |
| Sensation loss | No | Yes |
| Burning | No | Yes |

| **PSYCHIATRIC** | | |
|---|---|---|
| Nervousness, anxiety | No | Yes |
| Depression | No | Yes |

| **ENDOCRINE** | | |
|---|---|---|
| Heat or cold intolerance | No | Yes |
| Excessive thirst | No | Yes |

| **HEMATOLOGIC/LYMPHATIC** | | |
|---|---|---|
| Abnormal bleeding | No | Yes |
| Bleeding | No | Yes |

| **ALL/IMMUNOLOGIC** | | |
|---|---|---|
| Allergic Reaction | No | Yes |
| Recurrent infections | No | Yes |

SIGNATURE: _____ DATE: _____