Name: ______________________________________ Date of Birth: ____________________________________

Review of Systems

Have you had any of the following symptoms lately?

General

Symptom	Yes	No
Fatigue	O Yes	O No
Fever	O Yes	O No
Weight loss	O Yes	O No
Chills	O Yes	O No

Eyes

Symptom	Yes	No
Blurred vision	O Yes	O No
Vision changes	O Yes	O No

Ears

Symptom	Yes	No
Ear pain	O Yes	O No
Hearing loss	O Yes	O No

Nose, Throat

Symptom	Yes	No
Nasal congestion	O Yes	O No
Bloody nose	O Yes	O No

Lungs

Symptom	Yes	No
Shortness of Breath	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No

Heart

Symptom	Yes	No
Chest pain	O Yes	O No
Shortness of breath While sleeping	O Yes	O No

Breasts

Symptom	Yes	No
Drainage from nipple	O Yes	O No
Breast lump	O Yes	O No

Gastrointestinal

Symptom	Yes	No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Changes in bowels	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Blood in stool	O Yes	O No

Urinary

Symptom	Yes	No
Frequent urination	O Yes	O No
Painful urination	O Yes	O No
Blood in urine	O Yes	O No
Urinary leakage	O Yes	O No

Hematologic

Symptom	Yes	No
Bruises easily	O Yes	O No
Prolonged bleeding	O Yes	O No

Musculoskeletal

Symptom	Yes	No
Joint pain	O Yes	O No
Muscle pain	O Yes	O No
Back pain	O Yes	O No

Skin

Symptom	Yes	No
Skin rash	O Yes	O No
Itching	O Yes	O No

Neurological

Symptom	Yes	No
Headaches	O Yes	O No
Dizziness	O Yes	O No
Numbness	O Yes	O No

Psychiatric

Symptom	Yes	No
Difficulty sleeping	O Yes	O No
Feeling anxious	O Yes	O No
Feeling depressed	O Yes	O No

Endocrine

Symptom	Yes	No
Intolerant of cold	O Yes	O No
Intolerant of heat	O Yes	O No