

## REVIEW OF SYSTEMS

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Please check yes or no as deemed appropriate regarding the following symptoms

NO	YES	GENERAL	COMMENTS
		Chills	
		Fever	
		Night sweats	
NO	YES	CARDIOVASCULAR	COMMENTS
		Chest pain	
		Irregular heartbeat/palpitations	
		Leg swelling	
NO	YES	SKIN	COMMENTS
		Psoriasis	
		Itchy skin	
		Rash	
		Skin infections	
NO	YES	METABOLIC/ENDOCRINE	COMMENTS
		Diabetes	
		Thyroid problems	
NO	YES	HEENT	COMMENTS
		Blurred vision	
		Dysphagia (Difficulty swallowing)	
		Headache	
		Hearing loss	
		Ringing in ears	
		Vision loss	
NO	YES	GASTROINTESTINAL	COMMENTS

		Abdominal pain	
		Black tarry stools	
		Diarrhea	
		Heartburn	
		Jaundice	
<b>NO</b>	<b>YES</b>	<b>NEUROLOGICAL</b>	<b>COMMENTS</b>
		Difficulty walking	
		Muscle weakness	
		Paresthesia (numbness, tingling feeling)	
<b>NO</b>	<b>YES</b>	<b>PSYCHIATRIC</b>	<b>COMMENTS</b>
		Anxiety	
		Depression	
<b>NO</b>	<b>YES</b>	<b>RESPIRATORY</b>	<b>COMMENTS</b>
		Chest pain (respiratory)	
		Cough	
		Dyspnea (shortness of breath)	
<b>NO</b>	<b>YES</b>	<b>GENITOURINARY</b>	<b>COMMENTS</b>
		Frequent urination	
		Hematuria (blood in urine)	
<b>NO</b>	<b>YES</b>	<b>MUSCULOSKELETAL</b>	<b>COMMENTS</b>
		Back pain	
		Bone/joint symptoms	
		Myalgia (muscle pain)	
		Muscle weakness	
		Neck stiffness	
<b>NO</b>	<b>YES</b>	<b>IMMUNOLOGICAL</b>	<b>COMMENTS</b>
		Asthma	
		Contact dermatitis	
		Environmental allergies	