

REVIEW OF SYSTEMS

Please check if any of the following applies to you TODAY:

CONSTITUTIONAL

- | | | |
|--------------|--------------------------|-------|
| Weight Loss | <input type="checkbox"/> | _____ |
| Weight Gain | <input type="checkbox"/> | _____ |
| Fever | <input type="checkbox"/> | _____ |
| Fatigue | <input type="checkbox"/> | _____ |
| Night Sweats | <input type="checkbox"/> | _____ |
| Hot Flashes | <input type="checkbox"/> | _____ |

EYES

- | | | |
|----------------|--------------------------|-------|
| Double vision | <input type="checkbox"/> | _____ |
| Vision changes | <input type="checkbox"/> | _____ |

HENT

- | | | |
|---------------|--------------------------|-------|
| Headaches | <input type="checkbox"/> | _____ |
| Dizziness | <input type="checkbox"/> | _____ |
| Sore Throat | <input type="checkbox"/> | _____ |
| Sinus Pain | <input type="checkbox"/> | _____ |
| Nose Bleeding | <input type="checkbox"/> | _____ |
| Thyroid Mass | <input type="checkbox"/> | _____ |
| Neck Pain | <input type="checkbox"/> | _____ |

BREASTS

- | | | |
|------------------------|--------------------------|-------|
| Lumps | <input type="checkbox"/> | _____ |
| Tenderness | <input type="checkbox"/> | _____ |
| Swelling | <input type="checkbox"/> | _____ |
| Discharge | <input type="checkbox"/> | _____ |
| Pain in Breast | <input type="checkbox"/> | _____ |
| Abn. Changes in Breast | <input type="checkbox"/> | _____ |

CARDIOVASCULAR

- | | | |
|-----------------------|--------------------------|-------|
| Chest Pain | <input type="checkbox"/> | _____ |
| Irregular Heart Beats | <input type="checkbox"/> | _____ |
| Rapid Heart Rate | <input type="checkbox"/> | _____ |
| Fainting | <input type="checkbox"/> | _____ |
| Swelling of Legs | <input type="checkbox"/> | _____ |
| Varicose Veins | <input type="checkbox"/> | _____ |

RESPIRATORY

- | | | |
|---------------------|--------------------------|-------|
| Wheezing | <input type="checkbox"/> | _____ |
| Cough | <input type="checkbox"/> | _____ |
| Shortness of Breath | <input type="checkbox"/> | _____ |
| Spitting Up Blood | <input type="checkbox"/> | _____ |

GASTROINTESTINAL

- | | | |
|--------------------|--------------------------|-------|
| Nausea | <input type="checkbox"/> | _____ |
| Vomiting | <input type="checkbox"/> | _____ |
| Diarrhea | <input type="checkbox"/> | _____ |
| Constipation | <input type="checkbox"/> | _____ |
| Abdominal Pain | <input type="checkbox"/> | _____ |
| Bloody/Black Stool | <input type="checkbox"/> | _____ |
| Hemorrhoids | <input type="checkbox"/> | _____ |
| Jaundice | <input type="checkbox"/> | _____ |

GENITOURINARY

- | | | |
|------------------------|--------------------------|-------|
| Urgency of Urination | <input type="checkbox"/> | _____ |
| Frequency of Urination | <input type="checkbox"/> | _____ |
| Pain with Urination | <input type="checkbox"/> | _____ |
| Nighttime Urination | <input type="checkbox"/> | _____ |
| Losing Urine | <input type="checkbox"/> | _____ |

Notes

GENITOURINARY, Continued

- | | | |
|---------------------|--------------------------|-------|
| Decreased Sex Drive | <input type="checkbox"/> | _____ |
| Painful Intercourse | <input type="checkbox"/> | _____ |
| Possible Pregnancy | <input type="checkbox"/> | _____ |
| Genital Sores | <input type="checkbox"/> | _____ |

SKIN

- | | | |
|--------------------------------|--------------------------|-------|
| Rashes | <input type="checkbox"/> | _____ |
| Itching | <input type="checkbox"/> | _____ |
| Skin Dryness | <input type="checkbox"/> | _____ |
| Skin Lesions | <input type="checkbox"/> | _____ |
| Changes to Lesions or Moles | <input type="checkbox"/> | _____ |
| Acne | <input type="checkbox"/> | _____ |

NEUROLOGICAL

- | | | |
|--------------------------|--------------------------|-------|
| Muscular Weakness | <input type="checkbox"/> | _____ |
| Numbness or Tingling | <input type="checkbox"/> | _____ |
| Difficulty Concentrating | <input type="checkbox"/> | _____ |
| Memory Difficulties | <input type="checkbox"/> | _____ |
| Speech Difficulties | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | _____ |
| Loss of Balance | <input type="checkbox"/> | _____ |

MUSCULOSKELETAL

- | | | |
|------------------------|--------------------------|-------|
| Joint Pain or Swelling | <input type="checkbox"/> | _____ |
| Muscle Pain | <input type="checkbox"/> | _____ |
| Back Pain | <input type="checkbox"/> | _____ |

ENDOCRINE

- | | | |
|----------------------------|--------------------------|-------|
| Loss of Hair | <input type="checkbox"/> | _____ |
| Difficulty Tolerating Cold | <input type="checkbox"/> | _____ |
| Difficulty Tolerating Heat | <input type="checkbox"/> | _____ |

PSYCHIATRIC

- | | | |
|--------------------|--------------------------|-------|
| Anxiety | <input type="checkbox"/> | _____ |
| Depression | <input type="checkbox"/> | _____ |
| Impulsive Behavior | <input type="checkbox"/> | _____ |
| Suicidal Thoughts | <input type="checkbox"/> | _____ |
| Excessive Anger | <input type="checkbox"/> | _____ |
| Mood Swings | <input type="checkbox"/> | _____ |
| Emotional Abuse | <input type="checkbox"/> | _____ |
| Physical Abuse | <input type="checkbox"/> | _____ |
| Sexual Abuse | <input type="checkbox"/> | _____ |

HEMATOLOGIC/LYMPHATIC

- | | | |
|---------------------------------|--------------------------|-------|
| Bruises Frequently or Easily | <input type="checkbox"/> | _____ |
| Cuts do not stop Bleeding | <input type="checkbox"/> | _____ |
| Enlarged Lymph Nodes | <input type="checkbox"/> | _____ |

ALLERGIC/IMMUNOLOGIC

- | | | |
|--------------------|--------------------------|-------|
| Frequent Illness | <input type="checkbox"/> | _____ |
| Seasonal Allergies | <input type="checkbox"/> | _____ |

OTHER

1. _____
2. _____