

## Review of Systems

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_\_

Indicate if you are having any current problems, signs or symptoms in any of the following areas:

### ***General Wellness***

- Fever
- Chills
- Fatigue
- Weight Gain
- Weight Loss

### ***Eyes***

- Recent Vision Problem
- Double Vision
- Dry Eyes

### ***Ears / Nose / Throat***

- Decreased Hearing
- Hoarse Voice
- Sore Throat
- Nasal Congestion
- Vertigo
- Hearing Aid: Left / Right/ Bilateral / Other

### ***Lungs / Breathing***

- Shortness of Breath
- Cough
- Wheezing
- Sleep Apnea: CPAP / BiPAP

### ***Heart / Circulation***

- Chest Pain
- Palpitations
- Leg Swelling

### ***Diarrhea / Constipation***

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn
- Abdominal Pain
- Loss of Appetite
- Rectal Pain
- Bloating
- Change in Stool Color
- Change in Stool Consistency

### ***Urinary / Reproductive***

- Blood in Urine
- Change in Urine Stream
- Urinary Frequency
- Urinary Hesitancy
- Urinary Incontinence
- Irregular Menses

### ***Blood / Lymph***

- Anemia
- Bruising Tendency
- Bleeding Tendency

### ***Thyroid / Endocrine***

- Cold Intolerance
- Heat Intolerance
- Excessive Hunger
- Hot Flashes

### ***Muscles / Joints / Bones***

- Back Pain
- Neck Pain
- Joint Pain
- Joint Stiffness
- Restless Leg

### ***Skin***

- Rash
- Skin Lesion

### ***Neurological***

- Numbness
- Tingling
- Headache
- Memory Loss
- Seizures
- Tremor
- Weakness

### ***Psychiatric***

- Anxiety
- Depression
- Hallucinations
- Memory Difficulties
- Sleeping Problems
- Eating Disorder: Anorexia / Laxative Abuse / Binging / Induced Vomiting / Excessive Exercise

### **Physician Comments-ROS**