REVIEW OF SYSTEMS

PATIENT _____

DATE _____

Check all that apply to indicate if you currently have any of the symptoms below.

GENERAL
- ○ Chills/Fever
- ○ Loss of Appetite
- ○ Weight Loss
- ○ Excessive Fatigue

ALLERGY
- ○ Seasonal Allergies

NEUROLOGIC
- ○ Headache
- ○ Numb/Tingling
- ○ Incoordination
- ○ Dizziness
- ○ Seizures
- ○ Drop Attacks

EYES
- ○ Eye Pain
- ○ Blurred/Double Vision
- ○ Vision Changes

ENT
- ○ Hearing Loss
- ○ Difficulty Swallowing
- ○ Ringing Ears

RESPIRATORY
- ○ Productive Cough
- ○ Coughing Blood
- ○ Asthma
- ○ Wheezing
- ○ Trouble Breathing
- ○ COPD

CARDIAC
- ○ Chest Pain
- ○ Ankle Swelling
- ○ High Cholesterol
- ○ Palpitation
- ○ Shortness of Breath
- ○ High Blood Pressure

GI
- ○ Abdominal Pain
- ○ Nausea/Vomiting
- ○ Blood in Stool
- ○ Persistent Diarrhea
- ○ Difficulty Swallowing
- ○ Heartburn/Indigestion
- ○ Bowel Habit Changes
- ○ Dark Black Stools

GU
- ○ Painful Urination
- ○ Frequent Urination
- ○ Urinary Incontinence
- ○ Loss of Bladder Control
- ○ Blood in Urine

HEME
- ○ Night Sweats
- ○ Easy Bruising
- ○ Bleeding Problems

DERMATOLOGIC
- ○ Rash
- ○ Itching
- ○ Hives

PSYCH
- ○ Depression
- ○ Unusual Stress
- ○ Anxiety
- ○ Claustrophobia
- ○ Difficulty Sleeping

ENDOCRINE
- ○ Diabetes
- ○ Thyroid Disease

CANCER
- ○ Yes
- ○ No

PACEMAKER
- ○ Yes
- ○ No