

**Review of Systems**

Name:

Date of Birth:

Date:

<b>Constitutional:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Comments:								
<b>Eyes:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>			
Persistent Redness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Ears/Nose/Throat/Mouth:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>			
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Heavy snoring	<input type="checkbox"/>	<input type="checkbox"/>			
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Change in voice	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Respiratory</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
Phlegm/sputum production	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Chest discomfort or pressure	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Calf or buttock pain with walking	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool/black stool	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Genitourinary</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Urination at night	<input type="checkbox"/>	<input type="checkbox"/>	Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Leakage of urine	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>						
Comments:								

<b>Musculoskeletal</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Persistent or severe neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Persistent or severe joint pain	<input type="checkbox"/>	<input type="checkbox"/>			
Persistent or severe back pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramping	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Skin/Breasts</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	New or changing moles	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>			
Growths	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Neurological</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Falls	<input type="checkbox"/>	<input type="checkbox"/>	Involuntary movement	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness		
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Psychological</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>			
Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Feeling sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>			
Panic	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>			
Comments:								
<b>Endocrine</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Cold/Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Comments:								
<b>Blood/Lymphatics</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Excessive bruising	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Comments:								
<b>Allergy/Immune</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Severe allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
Comments:								