REVIEW OF SYSTEMS

NAME: _____ DATE: _____

DATE OF BIRTH: _____

DO YOU NOW OR HAVE YOU HAD WITHIN THE LAST 30 DAYS

	YES	NO		YES	NO		YES	NO
CONSTITUTIONAL SYMPTOMS			RESPIRATORY			INTEGUMENTARY(skin)		
Night sweats			Difficulty breathing			Rash		
Fever			Coughing up blood			New lesions		
Weight changes			Shortness of breath			Existing lesions-change		
Appetite changes								
			GI			NEUROLOGICAL		
EYES			Food intolerance			Sensory deficits		
Vision changes			Rectal pain			Seizures		
Double vision			Abdominal pain			Passing out		
Night blindness			Abdominal mass			Motor deficits		
			Rectal bleeding			Headaches		
EARS, NOSE, MOUTH & THROAT			Jaundice			Loss of memory		
Hearing loss			Bowel habit changes					
Ringing in the ears			Constipation			PSYCHIATRIC		
Loss of smell			Diarrhea			Emotional problems		
Nose bleeds			Vomiting					
Lumps in the throat			Heartburn			ENDOCRINE		
Difficulty swallowing						Insomnia		
Loss of taste			GU			Lethargy		
Hoarseness			Pain urinating			Heat intolerance		
			Difficulty urinating			Cold intolerance		
CARDIOVASCULAR			Increased night urinating			Palpitations		
Leg pain			Blood in urine					
Angina/chest pain						HEMATOLOGY/LYMPHATIC		
Ankle/leg swelling			MUSCULOSKETAL			Bleeding problems		
Dizziness			Back pain			Enlarged lymph glands		
Palpitations			Fractures/dislocations					
Fainting spells			Muscle/joint pain					
OTHERS:								
						Dr. Initials:		