Review of Systems

Please circle any symptoms you have had in the last 2 months

Patient Name: _____

Constitutional Symptoms
Fever
Chills
Sweats
Weight change of more than 10 lbs. _____
Loss of Appetite

Eyes
Blurred Vision
Double Vision
Eye Pain
Cataract

Ear, Nose, Throat, Mouth
Loss of Hearing
Ear Pain
Sore Throat
Sinus Problems

Respiratory
Cough
Shortness of Breath
Wheezing
Other

Cardiovascular
Chest Pain or Pressure
Leg Pain with Exercise
Varicose Veins
Other

Gastrointestinal
Abdominal Pain
Nausea or Vomiting
Constipation
Diarrhea
Other

Immunologic
Allergies
Frequent or Recurrent Infections
Other

Neurologic
Headaches
Weakness
Numbness or Tingling
Fainting or Loss of Consciousness
Tremor
Loss of Balance

Genitourinary
Painful Urination
Blood in the Urine
Difficulty Starting Urination
Slow Urine Stream
Urinary Frequency
Urinary Urgency
Do you wake at night to urinate?____ How many times? ____
Straining to Urinate
Incontinence/Leakage of Urine
Inability to Empty the Bladder

Adult Male Patients:
Difficulty with Erections
Pain During or After Sex
Other Problems with Sexual Function
Infertility

Adult Female Patients:
Abnormal Vaginal Bleeding
Vaginal Discharge
Infertility
Painful Intercourse
Other Sexual Dysfunction

Endocrine
Excessive Thirst
Excessive Hunger
Heat Intolerance
Cold Intolerance
Severe Fatigue

Integumentary
Skin Rash
Persistent Itching
Boils or Other Skin Infections
Other

Musculoskeletal
Pain or Stiffness of the Back, Neck or Joints
Bone Pain
Muscle Pain
Other

Lymphatic/Hematologic
Unusual Lumps or Masses
Abnormal Bleeding or Bruising
Blood Clots

Psychiatric
Depression
Anxiety
Substance Abuse
Other