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REVIEW OF SYSTEMS

Name: _____ **DOB:** _____

*** Please check your symptoms in required box, if no symptoms – check the NORMAL Box.**

General	**❑ NORMAL**
❑ Weight Gain	
❑ Weight Loss	
❑ Fever	
❑ Fatigue	
❑ Sleeping Problems	
❑ Memory Loss	

HEENT	**❑ NORMAL**
❑ Eye Glasses/Contacts	❑ Dry Mouth
❑ Headaches	❑ Dentures
❑ Hearing Loss	❑ Hoarseness
❑ Sore Throat	
❑ Snoring	
❑ Hearing Aids	

Psychiatric	**❑ NORMAL**
❑ Depression	❑ Mental Disorders
❑ Anxiety/Panic Attacks	

Endocrine	**❑ NORMAL**
❑ Loss of Hair	❑ Obesity
❑ Hot/Cold Intolerance	❑ Excessive Thirst

Neurological	**❑ NORMAL**
❑ Numbness/Tingling	❑ Seizures/Convulsions
❑ Stroke	❑ Multiple Sclerosis

Hematology	**❑ NORMAL**
❑ Bleeding Tendency	❑ Bruising Tendency

Dermatology	**❑ NORMAL**
❑ Rash or Sores	❑ Itching

Gastrointestinal	**❑ NORMAL**
❑ Nausea	❑ Bloating
❑ Vomiting	❑ Blood in Stool
❑ Diarrhea	❑ Jaundice
❑ Constipation	❑ Regurgitation
❑ Change in Appetite	❑ Ulcers
❑ Acid Reflux/Heartburn	❑ Abdominal Pain
❑ Belching	❑ Hemorrhoids

Genitourinary	**❑ NORMAL**
❑ Possible Pregnancy	
❑ Heavy Period Bleeding	❑ Prostate Problems
❑ Kidney Dialysis	❑ Blood in Urine
❑ Kidney Stones	❑ Sexual Problems
❑ Kidney Failure	❑ Trouble Urinating

Respiratory	**❑ NORMAL**
❑ Asthma	❑ Uses CPAP
❑ Emphysema	❑ Sleep Apnea
❑ Chronic Cough	
❑ Shortness of Breath	
❑ Coughing up Blood	
❑ Tuberculosis Exposure	

Cardiovascular	**❑ NORMAL**
❑ Chest Pain	❑ Palpitations
❑ Lightheaded/Dizzy	❑ Heart Failure
❑ Heart Murmur	❑ Pulmonary Embolism
❑ Pacemaker	❑ Blood Clots
❑ Irregular Heartbeat ❑ Fainting Spells	❑ Hypertension (high blood pressure)
❑ Heart Attack ❑ Swelling of Ankles	❑ Hypotension (low blood pressure) ❑ Varicose Veins

Signature: _____ **Date:** _____