Review of Systems (Please check the following for symptoms <u>now present</u>)

Patient Name (**please print**) _____ DOB _____Date_____

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Excessive Fatigue
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Other _____

Eyes:
- ☐ Use Glasses/Contacts
- ☐ Blurry Vision
- ☐ Eye Pain
- ☐ Pain Looking at Bright Lights
- ☐ Other _____

Ear/Nose/Throat:
- ☐ Hearing Problems
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Tooth Pain
- ☐ Sore Throat
- ☐ Voice Change
- ☐ Other _____

Cardiovascular:
- ☐ Chest Pain at Rest
- ☐ Chest Pain with Exertion
- ☐ Heart Fluttering
- ☐ Swollen feet or ankles
- ☐ Other _____

Respiratory:
- ☐ Recent Cough
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Pain with Breathing
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Other _____

Gastrointestinal:
- ☐ Abdomen Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Loss of appetite
- ☐ Heartburn/Acid Reflux
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Other _____

Genitourinary:
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Difficulty Controlling Urine
- ☐ Painful Menses
- ☐ Irregular Menstrual Cycle
- ☐ Heavy Menstrual Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Post-Menopausal Vaginal Bleeding
- ☐ Other _____

Musculoskeletal:
- ☐ New Joint Pains
- ☐ Joint Stiffness
- ☐ Back Pain
- ☐ Muscle Aches
- ☐ Other _____

Skin/Breast:
- ☐ Rashes
- ☐ Unusual Moles
- ☐ Breast Changes
- ☐ Other _____

Neurologic:
- ☐ Headaches
- ☐ Dizziness
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Loss of Coordination
- ☐ Fainting
- ☐ Seizures
- ☐ Tremor
- ☐ Memory Loss
- ☐ Other _____

Blood/Lymphatic:
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Swelling at the Neck
- ☐ Other _____

Endocrine:
- ☐ Difficulty Maintaining a Comfortable Temperature
- ☐ Hot Flashes
- ☐ Excessive Sweating
- ☐ Changing Skin Color
- ☐ Hair loss
- ☐ Infertility
- ☐ Other _____

Allergic/Immunologic:
- ☐ Seasonal Allergies
- ☐ Hives
- ☐ Other _____

Psychiatric:
- ☐ Excessive Sadness
- ☐ Excessive Stress/Anxiety
- ☐ Mood Swings
- ☐ Poor Concentration
- ☐ Significant Trouble Sleeping
- ☐ Suicidal Thoughts
- ☐ Other _____

Social:

Do you smoke_____ Packs per day_____ # of years_____

Do you drink alcohol_____ Drinks per week_____ # of years _____

How many cups of caffeine (coffee/tea/soda) do you drink each day _____

What physical exercise or sports do you participate in regularly_____