**REVIEW OF SYSTEMS**

# Please put a check mark by any symptoms that you have had recently. Please check “none” if you have not noticed any of the symptoms listed in that category.

**Cardiovascular:**

* Chest pain
* Shortness of breath
* Swelling of the feet
* Racing Pulse
* Irregular heart beat
* Is your blood pressure under control?
  + Yes
  + No
  + Unsure
* None

# Constitutional:

* Fever
* Weight loss
* Fatigue
* Loss of Appetite
* Chills
* Night Sweats
* Poor appetite
* None

# Endocrine:

* Excess thirst
* Excessive urination
* Heat Intolerance
* Cold Intolerance
* Hair loss
* Dry skin
* Is your blood sugar under control?
  + Yes
  + No
  + Unsure
* None

# Gastrointestinal:

* Abdominal pain
* Nausea
* Diarrhea
* Bloody stools
* Stomach Ulcers
* Constipation
* Trouble Swallowing
* Jaundice/yellow skin
* None

# Genitourinary:

* Genital sores or ulcers
* Kidney Failure/Problems
* Kidney stones
* Painful/difficult urination (Prostatitis)
* Testicular pain
* Urinary discharge
* None

# Hematology/Oncology:

* Easy bruising
* Prolonged bleeding
* None

# HENT:

* Hearing loss
* Sore throat
* Runny nose
* Dry mouth
* Jaw Claudication (pain in jaw when chewing)
* Ear ache
* None

# Integumentary:

* Rash
* Change in mole
* Skin sores
* Skin cancer
* Sever itching
* Loss of hair
* None

# Musculoskeletal:

* Muscle aches
* Joint pain
* Difficulty lying flat due to muscle pain
* Back pain
* None

# Neurologic:

* Weakness
* Headaches
* Scalp tenderness
* Dizziness
* Paralysis of extremities
* Tremor
* Stroke
* Numbness or tingling
* Seizures or convulsions
* Fainting
* None

# Respiratory:

* Wheezing
* Cough
* Coughing up blood
* Severe or Frequent colds
* Difficulty breathing
* None

**Name: Date of Birth: Date Completed:**