**COMPREHENSIVE REVIEW OF SYSTEMS**

**(Please circle Yes or No)**

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| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |  |
| **Constitutional** |  | **Genitourinary Female** |  |
| Weight change | Yes or No | Premenstrual Syndrome | Yes or No |
| Loss of appetite | Yes or No | Infertility | Yes or No |
| Fever | Yes or No | Dysmenorrheal | Yes or No |
| Weakness | Yes or No | Frequent yeast infections | Yes or No |
| Night sweats | Yes or No | Vaginal itching | Yes or No |
| Breast feeding (if applicable) | Yes or No | Intermenstrual bleeding | Yes or No |
|  |  | Pelvic pain | Yes or No |
| **Dermatology** |  | Sexual activity | Yes or No |
| Suspicious lesions | Yes or No | Irregular periods | Yes or No |
| Suspicious moles | Yes or No | Abnormal vaginal discharge | Yes or No |
| Rash | Yes or No | **Ophthalmology** |  |
| Itching | Yes or No |  |
| Dry or sensitive skin | Yes or No | Eye irritation | Yes or No |
| Photosensitivity | Yes or No | Drainage from eyes | Yes or No |
| Hives | Yes or No | Blurring of Vision | Yes or No |
| Hair loss | Yes or No | **Hematology** |  |
| Lumps | Yes of No |  |
| Jaundice | Yes or No | Easy bruising | Yes or No |
| **ENT** |  | Swollen glands | Yes or No |
|  | Fatigue | Yes or No |
| Nose bleeds | Yes or No | **Endocrinology** |  |
| Change in voice | Yes or No |  |
| Sore throat | Yes or No | Excessive thirst | Yes or No |
| Difficulty swallowing | Yes or No | Excessive sweating | Yes or No |
|  |  | Excessive urination | Yes or No |
| **Respiratory** |  | Cold intolerance | Yes or No |
| Shortness of breath | Yes or No | Heat intolerance | Yes or No |
| Chest tightness | Yes or No |  |  |
| Cough | Yes or No | **Allergy** |  |
| Wheezing | Yes or No | Runny nose | Yes or No |
| Congestion | Yes or No | Scratchy throat | Yes or No |
| **Gastroenterology** |  | Itchy eyes | Yes or No |
|  | Sneezing | Yes or No |
| Blood in stool | Yes or No | Ear fullness | Yes or No |
| Diarrhea | Yes or No | Stuffy nose | Yes or No |
| Vomiting | Yes or No | Cough | Yes or No |
| Constipation | Yes or No | **Musculoskeletal** |  |
| Nausea | Yes or No |  |
| Abdominal pain | Yes or No | Joint stiffness | Yes or No |
| Change in bowel habits | Yes or No | Leg cramps | Yes or No |
|  |  | Joint pain | Yes or No |
| **Psychology** |  | Joint swelling | Yes or No |
| Depression | Yes or No | Back pain | Yes or No |
| High stress | Yes or No | Neck pain | Yes or No |
| Mood swings | Yes or No | Muscle aches | Yes or No |
| Suicidal ideation | Yes or No |  |  |
| Obsessive-compulsive | Yes or No | **Urology** |  |
|  |  | Difficulty urinating | Yes or No |
|  |  | Blood in urine | Yes or No |
| **Neurology** |  | urinary urgency | Yes or No |
| Headache | Yes or No | Frequent urination | Yes or No |
| Tingling numbness | Yes or No | Urinary incontinence | Yes or No |
| Seizures | Yes or No |  |  |
| Dizziness | Yes or No | **Cardiology** |  |
| Focal weakness | Yes or No | Palpitations | Yes or No |
|  |  | Chest pains | Yes or No |
|  |  | High blood Pressure | Yes or No |