REVIEW OF SYSTEMS

Review of systems (Please check all that apply):

General
- ☐ weight change
- ☐ appetite change
- ☐ fever/chills
- ☐ sweats/ night sweats
- ☐ fatigue
- ☐ lumps/ bumps
- ☐ rashes
- ☐ hair/ nail changes

HEENT
- ☐ headaches
- ☐ vision changes
- ☐ glasses/ contacts nodes
- ☐ hearing loss
- ☐ ringing in ears
- ☐ nose bleeds
- ☐ nasal polyps
- ☐ mouth/ gum sores
- ☐ dentures
- ☐ hoarseness

Heart/ Lung/Chest
- ☐ chest pain
- ☐ shortness of breath
- ☐ palpitations
- ☐ heart murmur
- ☐ leg swelling
- ☐ leg cramps
- ☐ vascular problems
- ☐ cough (phlegm/ blood)
- ☐ bronchitis
- ☐ breast mass
- ☐ nipple discharge
- ☐ scoliosis

Gastrointestinal
- ☐ vomiting
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ heartburn
- ☐ yellow jaundice
- ☐ hemorrhoids
- ☐ stool changes (shape/ color)

Genitourinary
- ☐ burning
- ☐ frequent urination
- ☐ incontinence
- ☐ blood in urine
- ☐ penis sores/ discharge
- ☐ testicle pain/ lumps
- ☐ vaginal sores/ discharge
- ☐ sexual difficulties
- ☐ pelvic pain
- ☐ abnormal pap
- ☐ menstrual irregularities
- ☐ menopause: Age_____

Neuromuscular
- ☐ fainting/ dizziness
- ☐ tremor
- ☐ weakness/ paralysis
- ☐ difficulty walking
- ☐ difficulty sleeping
- ☐ frequent infections
- ☐ early morning awakening
- ☐ forgetfulness
- ☐ numbness/tingling
- ☐ nervousness
- ☐ old fractures
- ☐ joint swelling

Endocrine/ Hematology
- ☐ heat/ cold intolerance
- ☐ excessive thirst
- ☐ hormone treatment
- ☐ thyroid nodule/ goiter
- ☐ anemia
- ☐ blood transfusion
- ☐ bleeding problems
- ☐ swollen lymph

☐ **OTHER**

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Explanation:

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When was your last? (Please list month/year)

EKG_______________
Mammogram_______________
Blood work_______________
Flu shot_______________
Eye exam_______________

Stool Guaiacs_______________
Pap Smear_______________
Flexible Sigmoidoscopy_______________
Pneumovax_______________
Dental exam_______________

Chest X-ray_______________
Digital Rectal exam_______________
Stress Test_______________
Tetanus Shot_______________
Bone Density_______________

Patient Signature______________________________ Date_______________

Review Date:_______________

Review Date:_______________