Review of Systems

Name:_________________________________ Date:__________

Tobacco Use: Yes / No Type _________________ Age Quit_______
Alcohol Use: Yes / No Amount? __________

PLEASE CIRCLE "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

Constitutional

Fatigue	Y	N
Fever	Y	N
Night sweats	Y	N
Weakness	Y	N
Unexplained weight gain	Y	N
Unexplained weight loss	Y	N

Ears/Nose/Throat

Hearing loss	Y	N
Sinus problems	Y	N

Respiratory

Asthma	Y	N
Cough	Y	N
Wheezing	Y	N

Cardiovascular

Chest pressure	Y	N
Irregular heartbeat	Y	N

Gastrointestinal

Constipation	Y	N
Diarrhea	Y	N
Nausea/vomiting	Y	N

Genitourinary

Difficult or painful urination	Y	N
Blood in Urine	Y	N

Metabolic/Endocrine

Cold intolerance	Y	N
Heat intolerance	Y	N
Excessive Thirst	Y	N
Increased Appetite	Y	N
Excessive Urination	Y	N

Neurological

Dizziness	Y	N
Headache	Y	N
Numbness	Y	N
Difficulty Walking	Y	N

Psychiatric

Depression	Y	N
Irritability Changes	Y	N

Integumentary

Rash	Y	N
Skin lesion/nodules	Y	N

Musculoskeletal

Arthritis	Y	N
Joint swelling	Y	N
Muscle weakness	Y	N

Hematologic/Lymphatic

Abnormal Bleeding	Y	N
Abnormal Bruising	Y	N

Immunologic

Environmental allergies	Y	N
Food allergies	Y	N