Review of Systems

Last Name:_____ First Name:_____ Date of Birth:_____

Please circle "yes" or "no" to indicate whether you have had the symptoms listed below in the last month.

Constitution			**Respiratory**			**Endocrine**			**Neurological**		
Appetite change	Yes	No	Chest tightness	Yes	No	Hot flashes	Yes	No	Dizziness	Yes	No
Chills	Yes	No	Cough	Yes	No				Gait or balance problem	Yes	No
Sweating	Yes	No	Coughing up blood	Yes	No	**Genitourinary**			Headaches	Yes	No
Fatigue	Yes	No	Shortness of breath	Yes	No	Difficulty urinating	Yes	No	Light-headedness	Yes	No
Fever	Yes	No	Wheezing	Yes	No	Painful urination	Yes	No	Numbness	Yes	No
Weight change	Yes	No				Urinary frequency	Yes	No	Seizures	Yes	No
			Cardiovascular			Blood in urine	Yes	No	Speech difficulty or change	Yes	No
HEENT			Chest pain	Yes	No	Incontinence	Yes	No	Extremity weakness	Yes	No
Hearing loss	Yes	No	Leg Swelling	Yes	No				Tremor	Yes	No
Lump/Mass	Yes	No	Palpitations	Yes	No	**Musculoskeletal**			Loss of consciousness	Yes	No
Mouth sores	Yes	No				Joint pain	Yes	No	Tingling	Yes	No
Nosebleeds	Yes	No	**Gastrointestinal**			Back pain	Yes	No	Sensory change	Yes	No
Sore throat	Yes	No	Abdominal bloating	Yes	No	Muscle pain	Yes	No	Global weakness	Yes	No
Tinnitus	Yes	No	Abdominal Pain	Yes	No	Neck pain	Yes	No	Memory Loss/ Decline	Yes	No
Trouble swallowing	Yes	No	Blood in stool	Yes	No	Neck stiffness	Yes	No			
Voice change	Yes	No	Constipation	Yes	No	Falls	Yes	No	**Hematologic/Lymph**		
			Diarrhea	Yes	No				Swollen lymph nodes	Yes	No
Eyes			Nausea	Yes	No	**Skin**			Bruising too easily	Yes	No
Eye problems	Yes	No	Rectal pain	Yes	No	Itching	Yes	No			
Eye pain	Yes	No	Vomiting	Yes	No	Rash	Yes	No	**Psychiatric**		
Blurry vision	Yes	No	Incontinence	Yes	No	Wound healing issues	Yes	No	Anxiety	Yes	No
Loss of vision	Yes	No							Confusion	Yes	No
Double vision	Yes	No							Decreased concentration	Yes	No
									Depression	Yes	No
									Sleep disturbance	Yes	No
									Suicidal thoughts	Yes	No

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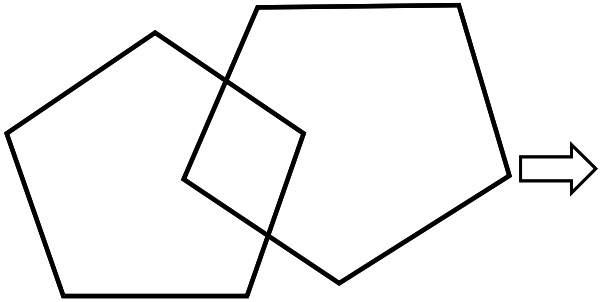
Please draw a CLOCK here:	**Please copy this figure:** 
Please write a sentence here:	
Do you have any specific questions for your provider? (Please list below)	

Current Medications (Drug)	Dose	Frequency (times taken per day)