NAME:_____ **BIRTH DATE:** ____/____/_____

REVIEW OF SYSTEMS

Please Check (X) If Any Of The Following Applies To You NOW.

CONSTITUTIONAL		NOTES
Weight Loss	❑	
Weight Gain	❑	
Fever	❑	
Fatigue	❑	
Chills	❑	
Decreased Appetite	❑	
	❑	
EYES		
Vision changes	❑	
	❑	
HENT		
Headaches	❑	
Dizziness	❑	
Sore Throat	❑	
Sinus Congestion	❑	
Lightheadedness	❑	
Decreased hearing	❑	
	❑	
BREAST		
Lumps	❑	
Tenderness	❑	
Swelling	❑	
Discharge	❑	
Pain in Breast	❑	
	❑	
CARDIOVASCULAR		
Chest Pain	❑	
Shortness of Breath w/ Exertion	❑	
Rapid Heart Rate	❑	
Fainting	❑	
Swelling of legs	❑	
Varicose veins	❑	
	❑	
RESPIRATORY		
Wheezing	❑	
Cough	❑	
Shortness of breath	❑	
	❑	
GASTROINTESTINAL		
Nausea	❑	
Vomiting	❑	
Constipation	❑	
Abdominal Pain	❑	
	❑	
GENITOURNARY		
Urgency of urination	❑	
Frequency of urination	❑	
Pain with urination	❑	
Losing urine	❑	
Vaginal Irritation	❑	
Vaginal Discharge	❑	
Vaginal Itching	❑	
Vaginal Odor	❑	
Genital Sores	❑	

SKIN		NOTES
Rashes	❑	
Changes to Lesions or Moles	❑	
Acne	❑	
NEUROLOGICAL		
Muscular Weakness	❑	
Numbness or Tingling	❑	
Seizures	❑	
	❑	
MUSCULOSKELETAL		
Joint Pain or Swelling	❑	
Muscle Pain	❑	
	❑	
ENDOCRINE		
Loss of Hair	❑	
Difficulty Tolerating Cold	❑	
Difficulty Tolerating Heat	❑	
Excessive Thirst	❑	
Excessive Urination	❑	
	❑	
PSYCHIATRIC		
Anxiety	❑	
Depression	❑	
Sexual Abuse	❑	
	❑	
HEMATOLOGIC/ LYMPHATIC		
Enlarged lymph nodes	❑	
Tender lymph nodes	❑	
	❑	
ALLERGIC/IMMUNOLOGIC	❑	
Eczema	❑	
Seasonal Allergies	❑	
	❑	
OTHER		
1.	❑	
2.	❑	
3.	❑	