Review of Systems

Constitutional

NO YES
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Malaise
- ☐ ☐ Night Sweats
- ☐ ☐ Weight Gain
- ☐ ☐ Weight Loss

Other: _____

HEENT

NO YES
- ☐ ☐ Ear Drainage
- ☐ ☐ Ear Pain
- ☐ ☐ Eye Discharge
- ☐ ☐ Eye Pain
- ☐ ☐ Hearing Loss
- ☐ ☐ Nasal Drainage
- ☐ ☐ Sinus Pressure
- ☐ ☐ Sore Throat
- ☐ ☐ Visual Changes

Other: _____

Respiratory

NO YES
- ☐ ☐ Chronic Cough
- ☐ ☐ Cough
- ☐ ☐ Known TB Exposure
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing

Other: _____

Cardiovascular

NO YES
- ☐ ☐ Chest Pain
- ☐ ☐ Claudication
- ☐ ☐ Edema
- ☐ ☐ Palpitations

Other: _____

Genitourinary - FEMALE

NO YES
- ☐ ☐ Dysuria
- ☐ ☐ Hematuria
- ☐ ☐ Polyuria
- ☐ ☐ Urinary Frequency
- ☐ ☐ Urinary Incontinence
- ☐ ☐ Urinary Retention

Other: _____

Genitourinary - MALE

NO YES
- ☐ ☐ Dribbling
- ☐ ☐ Dysuria
- ☐ ☐ Hematuria
- ☐ ☐ Polyuria
- ☐ ☐ Slow Stream
- ☐ ☐ Urinary Frequency
- ☐ ☐ Urinary Incontinence
- ☐ ☐ Urinary Retention

Other: _____

Integumentary

NO YES
- ☐ ☐ Breast Discharge
- ☐ ☐ Breast Lump
- ☐ ☐ Brittle Hair
- ☐ ☐ Brittle Nails
- ☐ ☐ Hair Loss
- ☐ ☐ Hirsutism
- ☐ ☐ Hives
- ☐ ☐ Pruritus (itching)
- ☐ ☐ Mole Changes
- ☐ ☐ Rash
- ☐ ☐ Skin Lesion

Other: _____

Metabolic/Endocrine

NO YES
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Polydipsia (excessive thrist)
- ☐ ☐ Polyphagia (over eating)

Other: _____

Musculoskeletal

NO YES
- ☐ ☐ Back Pain
- ☐ ☐ Joint Pain
- ☐ ☐ Joint Swelling
- ☐ ☐ Muscle Weakness
- ☐ ☐ Neck Pain

Other: _____

Hematologic/Lymphatic

NO YES
- ☐ ☐ Easy Bleeding
- ☐ ☐ Easy Bruising
- ☐ ☐ Lymphadenopathy (swelling
- ☐ ☐ of lymph nodes)

Other: _____

Immunologic

NO YES
- ☐ ☐ Contact Allergy
- ☐ ☐ Environmental Allergies
- ☐ ☐ Food Allergies
- ☐ ☐ Seasonal Allergies

Other: _____

Colonoscopy:

NO YES
☐ ☐ **Date:** _____

Mammogram:

NO YES
☐ ☐ **Date:** _____

Gastrointestinal

NO	YES	
☐	☐	Abdominal Pain
☐	☐	Blood in Stools
☐	☐	Change in Stools
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Loss of Appetite
☐	☐	Nauseau
☐	☐	Vomiting

Other: _____

Neurological

NO	YES	
☐	☐	Dizziness
☐	☐	Extremity Numbness
☐	☐	Extremity Weakness
☐	☐	Gait Disturbance
☐	☐	Headache
☐	☐	Memory Loss
☐	☐	Seizures
☐	☐	Tremors

Other: _____

Psychiatric

NO	YES	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Insomnia

Other: _____

Past Tests/Diagnostics/Labs

Date	Type

Immunizations	**Date**
Flu Shot:	
Pneumonia:	
Tetanus:	

Patient Signature: _____

Date of Birth: _____