

REVIEW OF SYSTEMS

NAME _____

DATE _____

REVIEW OF SYSTEMS QUESTIONNAIRE

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (Please check all that apply)

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> FEVER <input type="checkbox"/> WEIGHT CHANGE (☐ up ☐ down) <input type="checkbox"/> SLEEP PROBLEMS <input type="checkbox"/> DRENCHING SWEATS AT NIGHT <input type="checkbox"/> UNEXPLAINED FATIGUE <input type="checkbox"/> PROBLEMATIC HEADACHES <input type="checkbox"/> VISUAL CHANGES <input type="checkbox"/> WEAR GLASSES OR CONTACTS <input type="checkbox"/> PERIPHERAL VISION LOSS <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING EARS <input type="checkbox"/> DIZZINESS, SPINNING <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> DENTURES <input type="checkbox"/> ALLERGIES <input type="checkbox"/> SINUS PROBLEMS <input type="checkbox"/> PERSISTENT HOARSENESS/VOICE CHANGE <input type="checkbox"/> FREQUENT SORETHROATS <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> DENTAL PROBLEMS, SORES IN MOUTH <input type="checkbox"/> EXCESSIVE SNEEZING <input type="checkbox"/> LOUD SNORING <input type="checkbox"/> PERSISTENT COUGH <input type="checkbox"/> COUGHING UP BLOOD <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> WHEEZING <input type="checkbox"/> WAKING ABRUPTLY SHORT OF BREATH <input type="checkbox"/> LEG CRAMPS DURING WALKING <input type="checkbox"/> FLUTTERING IN THE CHEST (PALPITATION) <input type="checkbox"/> SWALLOWING PROBLEM <input type="checkbox"/> EARLY FILLING (WHEN EATING) <input type="checkbox"/> HEARTBURN <input type="checkbox"/> NAUSEA <input type="checkbox"/> ABDOMINAL PAINS <input type="checkbox"/> VOMITING <input type="checkbox"/> JAUNDICE <input type="checkbox"/> PERSISTENT FEELING OF NEED TO PASS STOOL <input type="checkbox"/> BRIGHT BLOOD IN STOOLS <input type="checkbox"/> BLACK TAR-LIKE STOOLS <input type="checkbox"/> CHANGE IN BOWEL HABITS <input type="checkbox"/> RECTAL PAIN <input type="checkbox"/> CHANGE IN STOOL CALIBER/ SIZE <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> STOMACH PAIN AFTER FATTY FOODS <input type="checkbox"/> INDIGESTION <input type="checkbox"/> EXCESSIVE GAS <input type="checkbox"/> URINE COLOR CHANGE <input type="checkbox"/> PAINFUL URINATION <input type="checkbox"/> INCREASED FREQUENCY OF URINE <input type="checkbox"/> LOSS OF URINARY CONTROL, LEAKING <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> CHANGE IN ☐ SEX DRIVE OR ☐ PERFORMANCE <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> JOINT SWELLING | <ul style="list-style-type: none"> <input type="checkbox"/> SIGNIFICANT BACK PAIN <input type="checkbox"/> MUSCLE CRAMPS <input type="checkbox"/> COLDNESS OF EXTREMITIES <input type="checkbox"/> LOSS OF MUSCLE MASS <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> RASHES <input type="checkbox"/> PERSISTENT SORES <input type="checkbox"/> CHANGE IN MOLES <input type="checkbox"/> ITCHING <input type="checkbox"/> NUMBNESS <input type="checkbox"/> WEAKNESS/PARALYSIS <input type="checkbox"/> MEMORY CHANGES <input type="checkbox"/> ANXIETY, NERVOUSNESS <input type="checkbox"/> COORDINATION/BALANCE PROBLEMS <input type="checkbox"/> DEPRESSION <input type="checkbox"/> APPETITE CHANGE (☐ up ☐ down) <input type="checkbox"/> PASSING OUT, FAINTING <input type="checkbox"/> STRESS <input type="checkbox"/> SLURRED SPEECH <input type="checkbox"/> TREMORS <input type="checkbox"/> EASY BRUISING <input type="checkbox"/> EXCESSIVE BLEEDING <input type="checkbox"/> SWOLLEN LYMPH GLANDS <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> COLD INTOLERANCE <input type="checkbox"/> EXCESSIVE THIRST <input type="checkbox"/> DRY SKIN <input type="checkbox"/> CHANGE IN HAIR DISTRIBUTION <input type="checkbox"/> CHANGES IN SIZE HANDS/FEET <p>MEN:</p> <ul style="list-style-type: none"> <input type="checkbox"/> URINARY HESITANCY <input type="checkbox"/> DRIBBLING AFTER URINATION <input type="checkbox"/> SWELLING/LUMP IN TESTICLE <input type="checkbox"/> AWAKENING TO URINATE MORE THAN TWICE NIGHTLY <input type="checkbox"/> WEAK URINE STREAM <p>WOMEN:</p> <ul style="list-style-type: none"> <input type="checkbox"/> HOT FLASHES <input type="checkbox"/> IRREGULAR MENSES <input type="checkbox"/> SEVERE MENSTRUAL CRAMPS <input type="checkbox"/> HEAVY PERIODS <input type="checkbox"/> PELVIC PAIN <input type="checkbox"/> SPOTTING BETWEEN PERIODS <input type="checkbox"/> BREAST LUMPS <input type="checkbox"/> BREAST PAIN <input type="checkbox"/> BREAST DISCHARGE <input type="checkbox"/> PAINFUL INTERCOURSE <input type="checkbox"/> VAGINAL DISCHARGE <p>HISTORY OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> ABNORMAL CHEST XRAY <input type="checkbox"/> ABNORMAL EKG <input type="checkbox"/> DISABILITY <input type="checkbox"/> HEART MURMUR |
|---|---|

COMPLETE THIS SIDE ONLY

Please Initial _____