Review of Systems (Please check the following for symptoms <u>now present</u>)

Patient Name (please print)_____DOB_____Date_____

General:
- ☐ Fever
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Chills
- ☐ Fatigue/Malaise
- ☐ Other_____

Eyes:
- ☐ Vision Changes
- ☐ Eye Irritation
- ☐ Other_____

Ears/Nose/Throat:
- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Teeth Problems
- ☐ Other_____

Cardiovascular:
- ☐ Chest Pain
- ☐ Heart Fluttering
- ☐ Swollen Feet or Ankles
- ☐ Other_____

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Other_____

Gastrointestinal:
- ☐ Abdomen Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loss of Appetite
- ☐ Diarrhea
- ☐ Vomiting Blood
- ☐ Reflux
- ☐ Other_____

Genitourinary:
- ☐ Difficulty Controlling Urine
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Other_____

Women
- ☐ Painful Menses
- ☐ Irregular menstrual Cycle
- ☐ Vaginal Discharge

Musculoskeletal:
- ☐ Muscle Aches
- ☐ Joint Pains
- ☐ Back Pain
- ☐ Other_____

Skin/Breast:
- ☐ Unusual Moles
- ☐ Rashes
- ☐ Breast Changes
- ☐ Other_____

Neurologic:
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremor
- ☐ Other_____

Psychiatric:
- ☐ Excessive Sadness
- ☐ Significant Trouble Sleeping
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Memory Loss
- ☐ Other_____

Endocrine:
- ☐ Intolerance to Cold/Heat
- ☐ Excessive Hair Loss
- ☐ Other_____

Blood/Lymphatic:
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Other_____

Allergic/Immunologic:
- ☐ Sinus Pressure
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Other_____

Social:

Do you smoke _____Packs per day_____ # of years _____

Do you drink alcohol_____ Drinks per week_____ # of years_____

How many cups of caffeine (coffee/tea/soda) do you drink each day_____

What physical exercise or sports do you participate in regularly_____