## **Review of Systems** \_\_\_\_\_ Date: \_\_\_\_\_

Ple	ease check any of the following that apply	to vou:
General information	√ EENT continued	√ GU female continued
Recent weight change	Loss of hearing	Urinary tract infections
Weakness / Fatigue	Ringing in ears	Benign tumors
Fever	Ear infections	Blood in Urine
Fainting spells	Vertigo	Painful urination
Nausea	Discharge from ears	Vaginal discharge
Vomiting	Sinus problems	Currently pregnant
Nervousness	Nosebleeds	Use of birth control pills
Anxiousness	Loss of smell	Data of last account of a last 2s. I
Irritability	Nasal discharge	Date of last menstrual period
Sleeping Disorders	Tooth pain	Onset of menopause
		Onset of menopause
Depression	Mouth / Tongue sores	Datas of the following everyor
Cancer (If yes type(s)	Frequent sore throats	Dates of the following exams;
	Difficulty swallowing	Pelvic Pap Smear
	Thyroid problems	Pap Smear
	Jaw / TMJ pain	Breast Sexually transmitted diseases
Implants (If yes, where?)		
	√ Respiratory (lung)	Type:
	Difficulty breathing	
	Chronic cough	
	Asthma	√ Genito-Urinary
Neuro-musculo-skeletal	Bronchitis	Male:
Neck pain	Emphysema	Prostate problems
Neck stiffness	Tuberculosis / Pneumonia	Hernia
Shoulder pain	Date of last chest x-ray	Penile discharge
Arm pain	Bato of fact offset x ray	Blood in urine
Wrist / Hand pain	√ Cardiovascular (heart)	Painful / Frequent urination
Numbness Arms or Hand	Chest pain	Testicular pain
	Shortness of breath	resticular pairi
Upper back pain		Datas of the following evens
Lower back pain	Palpitations	Dates of the following exams;
Hip pain	Night Sweats	Prostate
Leg pain	Cold hands and feet	PSASexually transmitted diseases
Ankle / Foot Pain	High / Low blood pressure	Sexually transmitted diseases
Numbness Legs or Feet	Heart Murmur	Type:
Joint Swelling	EKG / ECG history	
Tension		
Loss of balance	√ Gastrointestinal (stomach)	
	Loss of appetite	√ Endocrine
Head	Indigestion	Cold or Heat intolerance
Headaches	Constipation	Excessive sweating
Concussion	Diarrhea	Excessive thirst or hunger
Dizziness	Bloody stool	Diabetes
Memory Problems	Abdominal pain	Insulin dependent Y / N
Seizures / Convulsions	Excessive gas	Kidney Problems
	Loss of Bowel / Bladder control	
Eyes/Ears/Nose/Throat	Liver problems	√ Social History
Eyes sensitive to light		Tobacco use- type
Wear glasses / Contacts	√ Genito-Urinary	Alcohol use x /
Blurred / Double vision	Female:	Recreational drugs

Patient Name: \_\_\_\_\_