NAME:__________________________ DOB:_________ TODAY'S DATE:________

REVIEW OF SYSTEMS: Please circle only those that are pertinent to today's visit.

Constitutional

Fever	Yes	No
Chills	Yes	No
Weight change	Yes	No
Fatigue	Yes	No
Headache	Yes	No

Eyes

Double/blurry vision	Yes	No
Glaucoma	Yes	No
Contact lenses/glasses	Yes	No

Ears, Nose, Throat

Earaches	Yes	No
Hearing loss	Yes	No
Nose bleeds	Yes	No
Sore throat	Yes	No
Dry mouth	Yes	No
Bleeding gums	Yes	No
Mouth Sores	Yes	No
Swollen glands	Yes	No

Breast

Lumps	Yes	No
Tenderness/swelling	Yes	No
Nipple discharge	Yes	No

Cardiac

Chest pain	Yes	No
Palpitations	Yes	No
Dizziness	Yes	No
Heart trouble	Yes	No
Loss of consciousness	Yes	No
Swelling of hands/feet	Yes	No

Respiratory

Cough	Yes	No
Shortness of breath	Yes	No
Wheezing/asthma	Yes	No
Painful breathing	Yes	No

Gastrointestinal

Abdominal pain	Yes	No
Frequent constipation	Yes	No
Frequent diarrhea	Yes	No
Indigestion/heartburn	Yes	No
Nausea/vomiting	Yes	No
Ulcers	Yes	No

Genitourinary

Incomplete emptying	Yes	No
Painful urination or burning	Yes	No
Urinary frequency	Yes	No
Urinary urgency	Yes	No
Blood in urine	Yes	No
Urinary incontinence	Yes	No
Kidney stones	Yes	No
Unusual vaginal discharge	Yes	No
Unusual vaginal odor	Yes	No
Vulvar itching or burning	Yes	No
Vaginal itching or burning	Yes	No
Pelvic pain	Yes	No
Abnormal bleeding	Yes	No
Sexual difficulty	Yes	No

Integumentary (Skin)

Nodules	Yes	No
Change in moles/freckles	Yes	No
Change in hair growth/texture	Yes	No
Rash/itching	Yes	No
Varicose veins	Yes	No

Neurologic

Numbness/tingling	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Head injury	Yes	No

Musculoskeletal

Back pain	Yes	No
Weakness	Yes	No
Joint pain/stiffness	Yes	No
Swelling of legs	Yes	No

Endocrine

Excessive thirst	Yes	No
Temperature intolerance	Yes	No
Excessive urination	Yes	No
Hot flushes	Yes	No
Insomnia	Yes	No
Thyroid disease	Yes	No
Diabetes	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Mood swings	Yes	No

Lymph

Swollen glands	Yes	No
Easy bruising	Yes	No
Anemia	Yes	No