Patient Name_____ CY_____

Review of Systems

(Please check any recent symptoms)

General

☐Weight loss or gain ☐Fever or chills ☐Fatigue

Skin

☐Rashes ☐Itching ☐Dryness

Head

☐Headache ☐Head Injury

Ears

☐ Decreased hearing ☐Earache ☐Drainage

Eyes

☐Glasses or contacts ☐Blurry or double vision ☐Dry eyes

Nose

☐ Stuffiness ☐Itching ☐Nosebleeds ☐Discharge
☐Hay fever ☐Sinus pain

Mouth

☐Bad/sore teeth ☐Gum disease ☐Dry mouth
☐Dentures or bridges ☐Recent dental work

Throat

☐Sore tongue ☐Sore throat ☐Hoarseness

Neck

☐Lumps ☐Pain ☐Stiffness

Breasts

☐Lumps ☐Pain ☐Nipple discharge
☐Breastfeeding

Respiratory

☐Cough ☐Coughing up blood ☐Wheezing
☐Shortness of breath ☐Painful breathing

PLEASE TURN TO THE OTHER SIDE OF PAGE

Cardiovascular

☐Chest pain or discomfort ☐Palpitations
☐Shortness of breath with activity ☐Swelling
☐Shortness of breath lying down

Gastrointestinal

☐Swallowing difficulties ☐Heartburn ☐Yellow eyes or skin

Urinary

☐ Blood in urine ☐Painful urination ☐Increased frequency

Genital

Male
☐Sores ☐Lumps ☐Abnormal drainage
Female
☐Itching or rash ☐Pain ☐Lumps ☐Abnormal discharge

Musculoskeletal

☐Muscle or joint pain ☐Back pain ☐Swelling of joints

Neurologic

☐ Seizures ☐Numbness ☐Tingling

Hematologic

☐Easy bruising ☐Easy bleeding

Endocrine

☐Heat or cold intolerance ☐Sweating ☐Diabetes

Psychiatric

☐Nervousness ☐Memory loss ☐Depression

Physician Review_____