Name_____ D.O.B ___/___/___ Date___/___/___

Review of Systems: (Please circle all that currently apply)

		Feeling poorly	Recent weight gain
CONSITUTIONAL	Fever	Feeling tired	Recent weight loss
	Chills		
		Spots before my eyes	Dry eyes
EYES	Eye pain	Vision challenges	Itchy eyes
	Wearing glasses		
		Nose bleeds	Sore throat
EAR/NOSE/THROAT	Earaches	Sinus problems	Dental problems
	Loss of hearing		
		Fast heart rate	Leg swelling-edema
CARDIOVASCULAR	Chest pain	Slow heart rate	
	Palpitation		
		SOB when lying flat	Cough
RESPIRATORY	Shortness of breath (SOB)	Wheezing	SOB on exertion
	Respiratory distress in sleep		
		Constipation	Heartburn
GASTROINTESTINAL	Abdominal pain	Diarrhea	Black Stool
	Vomiting	Maroon colored stool	
	Nausea		
		Vulvar itching	Vaginal itching
OBGYN/GU	Abnormal bleeding	Midcycle bleeding	Pelvic pain
	Irregular menses	Bleeding after sex	Vaginal dryness
	Pain with menses	Vulvar pain	Vaginal odor
	Pain with sex		
	Decreased libido		
MUSCULOSKELETAL		Joint swelling	Joint stiffness
	Joint pain	Limb swelling	
	Limb pain		
INTEGUMENTARY(SKIN)		Itching	Breast pain
	Acne	Change in a mole	Breast lump
	Breast discharge		
NEUROLOGICAL		Dizziness	Limb weakness
	Confused	Headache/migraines	Difficulty walking
	Memory problem		
PSYCHIATRIC		Anxiety	Depression
	Suicidal	Sleep disturbance	Emotional issues
	Change in personality		
ENDOCRINE		Muscle weakness	Feeling weak
	Hair loss	Deepening of the voice	Dry Skin
	Hot flashes		
	Heat/cold intolerance		
HEMATOLOGY/IMMUNOLOGY	Easy bleeding	Swollen glands	Easy bruising
	Seasonal allergies		

Name_____ D.O.B ___/___/___ Date___/___/___

Review of Systems: (Please circle all that currently apply)