

REVIEW OF SYSTEMS

Patient Name: _____

Date of Birth: _____

CONSTITUTIONAL:

Fever Chills Night Sweats Fatigue Loss of Appetite NONE

EYES:

Blurred vision Double Vision Discharge Itching Pain Redness
 Sensitive to light Yellow eyes NONE

EARS, NOSE, THROAT, MOUTH:

Ears: Pain Bleeding Drainage Ringing Hearing loss NONE

Nose: Bleeding Congestion Discharge NONE

Throat: Pain Swelling Voice Change Hoarseness NONE

Mouth: Bleeding Pain Swelling NONE

RESPIRATORY:

Cough Shortness of Breath Wheeze Cough up Blood Pain w/breathing NONE

CARDIOVASCULAR:

Chest Pain Arm pain Swelling of Legs Heart fluttering Dizzy Spells
 Passing out NONE

GASTROINTESTINAL:

Abdominal pain Nausea Vomiting Diarrhea Black Stools Constipation NONE
 Vomiting of Blood Bright red blood per rectum Trouble Swallowing Heartburn

GENITOURINARY:

Pain w/urine Blood in urine Frequency Incontinence Flank Pain NONE

Male: Discharge Penile Sore Testicle: Pain Swelling NONE

Female: Discharge Abnormal bleeding Pelvic pain Pregnant Pain w/intercourse NONE

NEUROLOGICAL:

Headache Dizziness Seizure Speech problem Problem walking
 Weakness Tremor Fainting Numbness NONE

MUSCULOSKELETAL: *Pain or swelling in:*

R L Neck Chest wall Rib(s) Back Shoulder Arm Elbow Forearm
 Wrist Hand Pelvis Hip Leg Knee Ankle Foot NONE

SKIN:

Rash Itching Jaundice Wounds NONE

HEMATOLOGIC:

Easy Bruising Easy Bleeding Swollen Glands NONE

ENDOCRINE:

Weight: Gain _____ lbs. Loss _____ lbs
Intolerance to: Cold Heat
Excessive: Thirst Hunger Urination NONE

PSYCHIATRIC:

Depression Anxiety Sleepless Hopeless Suicidal Hallucinations NONE