Review of Systems

Please completely fill in all the circles that apply

CONSTITUTIONAL	**O NONE OF THESE**	
Weight gain	O yes	O no
Weight loss	O yes	O no
Loss of appetite	O yes	O no
Fatigue	O yes	O no

NEUROLOGY	**O NONE OF THESE**	
Limb weakness	O yes	O no
Headache	O yes	O no
Limb numbness/tingling	O yes	O no
Seizures	O yes	O no
Tremor	O yes	O no
Limb burning/pain	O yes	O no
Insomnia	O yes	O no
Vertigo/dizziness	O yes	O no
Memory loss	O yes	O no
Difficulty walking	O yes	O no
Sciatica	O yes	O no

MUSCULOSKELETAL	**O NONE OF THESE**	
Joint pain	O yes	O no
Joint stiffness	O yes	O no
Neck pain	O yes	O no
Back pain	O yes	O no
Leg cramps	O yes	O no
Restless legs	O yes	O no

PSYCHOLOGY	**O NONE OF THESE**	
Depression	O yes	O no
Anxiety	O yes	O no

OPHTHALMOLOGY	**O NONE OF THESE**	
Double vision	O yes	O no
Vision loss	O yes	O no

ENT	**O NONE OF THESE**	
Trouble swallowing	O yes	O no
Loss of hearing	O yes	O no
Ringing in ears	O yes	O no
Loss of taste/smell	O yes	O no

Name:_____ **Date:**_____

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RESPIRATORY	**O NONE OF THESE**	
Wheezing	O yes	O no
Cough	O yes	O no
Snoring	O yes	O no
Shortness of breath	O yes	O no

CARDIOVASCULAR	**O NONE OF THESE**	
Fainting or blackouts	O yes	O no
Chest pain	O yes	O no
Palpitations	O yes	O no

GASTROENTEROLOGY	**O NONE OF THESE**	
Heartburn	O yes	O no
Nausea	O yes	O no
Vomiting	O yes	O no
Constipation	O yes	O no
Diarrhea	O yes	O no

UROLOGY	**O NONE OF THESE**	
Urine frequency	O yes	O no
Urinating at night	O yes	O no
Urinary urgency	O yes	O no
Urinary incontinence	O yes	O no

DERMATOLOGY	**O NONE OF THESE**	
Rash	O yes	O no
Itching	O yes	O no
Eczema	O yes	O no

ENDOCRINOLOGY	**O NONE OF THESE**	
Excessive thirst	O yes	O no
Excessive sweating	O yes	O no
Heat intolerance	O yes	O no
Cold intolerance	O yes	O no

HEMATOLOGY	**O NONE OF THESE**	
Easy bruising	O yes	O no
Easy bleeding	O yes	O no
Blood transfusion	O yes	O no

ALLERGY	**O NONE OF THESE**	
Seasonal allergies	O yes	O no
Sinus drainage	O yes	O no

Name:_____ **Date:**_____