Review of Systems

Name: _____
Date: _____

Please check if you have/had problems related to the area indicated.

	YES	NO
1. SYSTEMIC		
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
2. EYES		
Blurred Vision	☐	☐
Double Vision	☐	☐
Spots before eyes	☐	☐
3. EARS, NOSE & THROAT		
Loss of hearing	☐	☐
Sinus Problems	☐	☐
Earaches	☐	☐
Ringing in ears	☐	☐
Difficulty Swallowing	☐	☐
Frequent sore throat	☐	☐
4. LUNGS		
Chronic cough	☐	☐
Coughing up blood	☐	☐
Shortness of breath	☐	☐
Breathing Difficulty	☐	☐
Wheezing	☐	☐
5. HEART		
Chest Pain	☐	☐
Race/Skipping beats	☐	☐
Palpitations	☐	☐
6. GASTROINTESTINAL		
Loss of/Excessive appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Bloody Stool	☐	☐
Change in bowel habits	☐	☐
Indigestion	☐	☐
7. GENITOURINARY		
Urinary Frequency	☐	☐
Urgency	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Inability to control bladder	☐	☐
Missed periods	☐	☐
Loss of sex drive	☐	☐

	YES	NO
8. MUSCULOSKELETAL		
Joint swelling	☐	☐
Stiffness	☐	☐
Joint pain	☐	☐
Back pain	☐	☐
Loss of strength	☐	☐
9. SKIN/BREAST		
Rash	☐	☐
Lesions/moles	☐	☐
Itching	☐	☐
Discoloration	☐	☐
Breast pain	☐	☐
Nipple discharge	☐	☐
Breast lump	☐	☐
10. NERVOUS SYSTEM		
Headaches	☐	☐
Poor balance	☐	☐
Memory loss	☐	☐
Tremors	☐	☐
Numbness/tingling	☐	☐
Seizures	☐	☐
11. PSYCHIATRIC		
Anxiety	☐	☐
Fear	☐	☐
Difficulty concentrating	☐	☐
Suicidal thoughts	☐	☐
12. ENDOCRINE		
Excessive thirst	☐	☐
Excessive hunger	☐	☐
Excessive urination	☐	☐
Heat/cold intolerance	☐	☐
13. Lymph Nodes		
Skin discoloration	☐	☐
Enlarged nodes	☐	☐
Abdominal bruising	☐	☐

Other Problems:

_____

_____

_____

_____

Do you have an Advanced Care Plan? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐