REVIEW OF SYSTEMS

Please check Yes or No to ALL below

Constitutional

Yes	No	
☐	☐	Excessive daytime sleepiness
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Low energy
☐	☐	Trouble getting to sleep
☐	☐	Trouble staying asleep
☐	☐	Weight gain
☐	☐	Weight loss

Eyes

Yes	No	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Loss of vision

Ears, Nose, Mouth, and Throat

Yes	No	
☐	☐	Loss of sense of smell
☐	☐	Hearing loss
☐	☐	Ringing in your ears

Cardiovascular and Respiratory

Yes	No	
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Shortness of breath

Gastrointestinal

Yes	No	
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

Bladder & Sexual Function (Genitourinary)

Yes	No	
☐	☐	Discomfort and burning
☐	☐	Loss of bladder control
☐	☐	Loss of desire for sex
☐	☐	Menopause (women)
☐	☐	Trouble with erection (men)
☐	☐	Urgency to urinate

Skin

Yes	No	
☐	☐	Change in hair or nails
☐	☐	Change in skin color
☐	☐	Itching
☐	☐	Rash

Neurological

Yes	No	
☐	☐	Confusion
☐	☐	Falling down
☐	☐	Headaches
☐	☐	Incoordination
☐	☐	Involuntary movements or jerking
☐	☐	Lightheaded or dizzy
☐	☐	Loss of consciousness/fainting/passing out
☐	☐	Numbness
☐	☐	Seizure or convulsion
☐	☐	Spinning or vertigo
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Trouble speaking
☐	☐	Trouble walking
☐	☐	Weakness
☐	☐	Trouble swallowing

Musculoskeletal

Yes	No	
☐	☐	Back pain
☐	☐	Joint pain or swelling
☐	☐	Muscle pain or cramps
☐	☐	Neck pain

Endocrine

Yes	No	
☐	☐	Heat or cold intolerance
☐	☐	Increased thirst
☐	☐	Loss of hair

Memory, Thinking, Mood, Psychiatric

Yes	No	
☐	☐	Anxiety
☐	☐	Depressed mood
☐	☐	Hallucinations (seeing or hearing things)
☐	☐	Memory loss

Hematologic (blood) and lymphatic

Yes	No	
☐	☐	Anemia
☐	☐	Easy bruising or bleeding
☐	☐	Slow to heal after cuts

Allergic and Immune

Yes	No	
☐	☐	Allergic reaction to medicine or x-ray dye

SIGN HERE

Signature of Patient **Date**

Signature of person completing form **Date**
(if not patient)