

REVIEW OF SYSTEMS

* * PLEASE INDICATE IF YOU HAVE EXPERIENCED THE FOLLOWING SYMPTOMS

Cardiovascular	<input type="checkbox"/> Negative	<input type="checkbox"/> Chest Pain/Pressure/Heaviness/Tightness <input type="checkbox"/> Palpitations <input type="checkbox"/> Murmur <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting spells <input type="checkbox"/> Awake at night w/difficulty breathing <input type="checkbox"/> Require multiple pillows or upright position to sleep <input type="checkbox"/> Ankle/Leg Swelling Comments _____
Vascular	<input type="checkbox"/> Negative	<input type="checkbox"/> Transient Blindness <input type="checkbox"/> Non-healing foot ulcer <input type="checkbox"/> Pain/Cramping/Discomfort in buttocks, thigh, calf when walking Comments _____
General	<input type="checkbox"/> Negative	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weakness <input type="checkbox"/> Sweating <input type="checkbox"/> Fatigue <input type="checkbox"/> Nightsweats <input type="checkbox"/> Fever or Chills Comments _____
Skin	<input type="checkbox"/> Negative	<input type="checkbox"/> Hair or Nail Changes <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Dryness Comments _____
Eyes	<input type="checkbox"/> Negative	<input type="checkbox"/> Wear glasses/contacts <input type="checkbox"/> Vision Changes <input type="checkbox"/> Pain <input type="checkbox"/> Blurry Vision Comments _____
Ear, Nose, Throat	<input type="checkbox"/> Negative	<input type="checkbox"/> Headaches <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Dentures <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Migraine Headaches Comments _____
Pulmonary	<input type="checkbox"/> Negative	<input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Difficulty Breathing Comments _____
Gastrointestinal	<input type="checkbox"/> Negative	<input type="checkbox"/> Appetite Change <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Heartburn <input type="checkbox"/> Black, Tarry Stools <input type="checkbox"/> Blood in Stool Comments _____
Genitourinary	<input type="checkbox"/> Negative	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Pain with Sex <input type="checkbox"/> Abnormal Discharge <input type="checkbox"/> Erectile Dysfunction Comments _____
Endocrine	<input type="checkbox"/> Negative	<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Hair Loss <input type="checkbox"/> Tremor <input type="checkbox"/> Hormone Therapy Comments _____
Allergic History	<input type="checkbox"/> Negative	<input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Food Allergies <input type="checkbox"/> Latex Allergy Comments _____
Musculoskeletal	<input type="checkbox"/> Negative	<input type="checkbox"/> Trauma <input type="checkbox"/> Swelling in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout Comments _____
Blood-lymphatics	<input type="checkbox"/> Negative	<input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Prior Transfusions <input type="checkbox"/> Lymph Node Enlargement Comments _____
Neurologic	<input type="checkbox"/> Negative	<input type="checkbox"/> Seizures <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Memory Disturbance <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Weakness of arm/leg Comments _____
Psychologic	<input type="checkbox"/> Negative	<input type="checkbox"/> Mood Changes <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Drug, Alcohol Abuse <input type="checkbox"/> Anxiety-Panic <input type="checkbox"/> Depression Comments _____

Name _____ Date _____ Chart # _____ DOB _____