REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS OR PROBLEMS THAT IS **CHRONIC** OR **PERSISTENT.**
CIRCLE NONE IF NOTHING IN A CATEGORY APPLIES.

LUNG: NONE

_______ SHORTNESS OF BREATH
_______ COUGH

HEART PROBLEMS: NONE

_______ RACING/IRREGULAR
_______ CHEST PAIN/ANGINA
_______ PALPITATIONS
_______ HEART FAILURE

STOMACH PROBLEMS: NONE

_______ HEARTBURN
_______ NAUSEA/VOMITING
_______ CONSTIPATION
_______ DIARRHEA
_______ ULCERS
_______ HERNIA
_______ COLITIS/DIVERTICULITIS
_______ LIVER DISEASE

HEAD/NECK PROBLEMS: NONE

_______ HEADACHES
_______ SEVERE HEAD INJURY
_______ MOUTH ULCERS

EAR/NOSE PROBLEMS: NONE

_______ HEARING LOSS
_______ PAIN/DISCHARGE
_______ DIZZINESS/FAINTING
_______ NOSE BLEEDS
_______ TINNITUS/VERTIGO
_______ SINUS PAIN

NEUROLOGICAL: NONE

_______ NUMBNESS/TINGLING
_______ SEISURES/EPILEPSY
_______ WEEKNESS IN ARM/LEG

MOOD DISORDER: NONE

_______ ANXIOUS/NERVIOUS
_______ DEPRESSION

GENERAL: NONE

_______ WEIGHT LOSS/GAIN
_______ EXCESSIVE THIRST
_______ SLEEP DISTURBANCE
_______ HEAT/COLD INTOLERANCE
_______ LOSS CONSCIOUSNESS
_______ FEVER/CHILLS
_______ BLEED/BRUISE EASY
_______ ANEMIA
_______ LOSS OF MEMORY
_______ NIGHT SWEATS

URINARY: NONE

_______ FREQUENCY URINATION
_______ BLOOD IN URINE

GENITAL: NONE

_______ PROSTATE TROUBLE
_______ VAGINA/OVARIAN
_______ INFECTIOUS DISEASE

MUSCLE/JOINT: NONE

_______ PAIN/SWELLING
_______ GOUT
_______ STIFFNESS

PATIENT SIGNATURE ______________________________ DATE______________

REVIEWED WITH PATIENT__________________