REVIEW OF SYSTEMS

NAME: _____ **DATE:** _____

PLEASE CHECK ANYTHING THAT APPLIES WITHIN THE PAST SIX MONTHS

CONSTITUTIONAL
___Increased Thirst
___Loss of Appetite
___Problems with Eating
___Recent Weight Loss/Gain
___Weight Loss Medication
___Loose/Chipped Teeth
___Dentures
___Recent Dental Appointment
___Currently/Possibly Pregnant
___Sexually Transmitted Disease
___ IV Port
___Open Wounds/Sores
___Tooth Decay
___NONE APPLY

MUSCULOSKELETAL
___Joint Stiffness
___Joint Pain
___Joint Swelling
___Joint Redness
___Joint weakness
___Decreased Motion
___Arthritis
___NONE APPLY

EAR/NOSE/THROAT
___Hearing Problems
___Chronic Cough
___Recent Bronchitis
___Ear Infections
___Recent Sore throat
___Recent Cold
___NONE APPLY

OPHTHALMOLOGY
___Vision Problems
___Glaucoma
___NONE APPLY

RESPIRATORY
___Shortness of Breath
___Chest Pain
___NONE APPLY

CARDIOLOGY
___Night Sweat
___Swelling
___Sleep Apnea
___Use CPAP at Night
___NONE APPLY

GASTROENTEROLOGY
___Nausea/Vomiting
___Diarrhea
___Abdominal Pain
___NONE APPLY

DERMATOLOGY
___Rash
___Skin Problems
___Major Burns
___NONE APPLY

NEUROLOGY
___Memory Changes
___Speech Changes
___Weakness/Paralysis
___Dizziness/Fainting
___Epilepsy/Seizures
___NONE APPLY

UROLOGY
___Frequent Urination
___Recurrent UTI
___NONE APPLY

ENDOCRINOLOGY
___Fatigue
___NONE APPLY

HEMATOLOGY
___Easy Bruising/Bleeding
___NONE APPLY

PSYCHOLOGY
___Depression
___Anxiety/Stress
___Suicide Ideas
___Abuse: Verbal/Emotional/Physical
___Drug/Alcohol Dependency
___Falling/Staying Asleep
___NONE APPLY