

**REVIEW OF SYSTEMS AND SYMPTOMS**

This box to be filled out by office staff only

Name \_\_\_\_\_

Pulse:	Weight:
BP: /	Height:

Chief Complaint (main reason you are here today, mark all that apply):

General:

- fever
- chills
- sweats
- loss of appetite
- fatigue
- weakness
- weight loss
- sleep disorder

Eyes:

- blurring
- irritation
- vision loss
- eye pain
- glasses/contacts

Ears, Nose, Throat:

- ringing or buzzing
- decreased hearing
- hearing aids
- nasal congestion
- nosebleeds
- sore throat
- hoarseness
- dentures/partial

Cardiovascular:

- chest pain
- palpitations
- swelling in legs/feet

Respiratory:

- shortness of breath  
\_\_\_\_\_ at rest  
\_\_\_\_\_ with exercise
- cough
- sputum/phlegm
- coughing up blood
- Sleep Apnea
- use of a CPAP

Gastrointestinal:

- difficulty swallowing
- pain on swallowing
- nausea
- heartburn
- vomiting
- abdominal pain
- jaundice (yellow skin)
- gas/bloating
- diarrhea
- constipation
- change in bowels
- bloody stool
- black stool
- fecal incontinence

Genitourinary:

- urinary burning
- blood in urine
- nocturnal urination
- urinary frequency
- urinary incontinence
- pelvic pain
- genital sores
- currently pregnant

Musculoskeletal:

- joint pain
- joint swelling
- low back pain
- muscle weakness
- muscle cramps
- leg pain at night

Skin:

- rash
- itching
- dry skin
- unhealing ulcers/sores

Neurological:

- weakness
- paralysis
- abnormal sensation
- seizures
- tremors
- vertigo
- frequent falls
- frequent headaches
- headache

Psychiatric:

- depression
- anxiety
- memory loss
- suicidal ideation
- confusion

Endocrine:

- cold intolerance
- heat intolerance
- excessive thirst
- excessive urination

Hematological:

- bruising
- bleeding
- enlarged lymph nodes

Allergy:

- sneezing
- hay fever
- recurrent infections
- lactose intolerance
- wheat allergy (Celiac)

Appointment Date: _____
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