

**REVIEW OF SYSTEMS**  
(PATIENT TO DOCUMENT PRIOR TO SEEING DOCTOR)

Have you had any new symptoms?  Yes  No  
Do you have diabetes?  Yes  No

PATIENTS NAME: \_\_\_\_\_

**GENERAL:**

Weight loss?  Yes  No How much? \_\_\_\_\_  
Decrease in energy?  Yes  No  
Decrease in appetite?  Yes  No  
Night sweats?  Yes  No  
Fever?  Yes  No If so, how high? \_\_\_\_\_

**Head, Eyes, Ears, Nose, Throat:**

Sinus infection/pain?  Yes  No  
Ear pain?  Yes  No  
Change in hearing?  Yes  No  
Eye pain?  Yes  No  
Change in vision?  Yes  No  
Nasal discharge?  Yes  No  
Throat pain?  Yes  No

**CARDIAC:**

Chest pain?  Yes  No  
Shortness of breath?  Yes  No  
Fatigue?  Yes  No  
Episodes of shortness of breath at night?  Yes  No  
Decrease in ability to exert oneself?  Yes  No

**RESPIRATORY:**

Blood in sputum?  Yes  No  
Cough or change in cough?  Yes  No  
Shortness of breath when lying down?  Yes  No  
Mucous production with cough?  Yes  No

**GASTROINTESTINAL:**

Difficulty swallowing food?  Yes  No  
Pain with swallowing food?  Yes  No  
Indigestion?  Yes  No  
Nausea?  Yes  No  
Vomiting?  Yes  No  
Diarrhea?  Yes  No  
Abdominal bloating?  Yes  No  
Black stools?  Yes  No  
Blood from the rectum?  Yes  No

**GENITOURINARY:**

Burning with urination?  Yes  No  
Blood in urine?  Yes  No  
Increase in need to urinate?  Yes  No  
Increase in need to urinate at night?  Yes  No

**MUSCULOSKELETAL:**

Arthritis?  Yes  No  
Back pain?  Yes  No  
New back pain?  Yes  No  
Bone pain?  Yes  No  
Muscle soreness?  Yes  No  
Recent trauma or fractures?  Yes  No

**SKIN:**

Infections?  Yes  No  
Ulcers?  Yes  No  
Rashes?  Yes  No

**NEUROLOGICAL:**

Headaches?  Yes  No  
Troublesome or frequent headaches?  Yes  No  
Recent change in vision?  Yes  No  
Recent change in hearing?  Yes  No  
Change in ability to feel things?  Yes  No  
Painful sensations?  Yes  No  
Decrease in muscle strength?  Yes  No  
Decrease in ability to ambulate?  Yes  No

**PSYCHIATRIC:**

Change in mood?  Yes  No  
Change in behavior with family?  Yes  No  
Change in ability to think?  Yes  No  
Losing track of where one is, what time it is, or who one is?  Yes  No

**HEMATOLOGIC:**

Nosebleeds, rectal bleeding, or bleeding at other sites? (please specify)  Yes  No \_\_\_\_\_

**EXTREMITIES:**

Redness of a limb?  Yes  No  
Swelling of a limb?  Yes  No  
Discoloration of a limb?  Yes  No

TODAY'S MAIN COMPLAINT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*FOR OFFICE USE ONLY\*\*\***

HT \_\_\_\_\_ WT \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_

M.D. SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



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