

**CHECKLIST:
Review of Systems**

Patient Name _____

DOB: _____

Constitutional (General)

Fever
Night Sweats
Weight Gain
Weight Loss
Exercise Intolerance
None of the Above

Eyes

Dry Eyes
Irritation
Vision Change
None of the Above

Ears

Difficulty Hearing
Ear Pain
None of the Above

Nose

Frequent Nosebleeds
Nose/Sinus Problems
None of the Above

Mouth/Throat

Sore Throat
Bleeding Gums
Snoring
Dry Mouth
Oral Abnormalities
Mouth Ulcer
Teeth Abnormalities
Mouth Breathing
None of the Above

Cardiovascular

Chest Pain on Exertion
Arm Pain on Exertion
Shortness of Breath when Walking
Shortness of Breath when Lying Down
Palpitations
Known Heart Murmur
Light-headed on Standing
None of the Above

Wheezing
Shortness of Breath
Coughing up Blood
Sleep Apnea
None of the Above

Gastrointestinal

Abdominal Pain
Vomiting
Change in Appetite
Black or Tarry Stools
Frequent Diarrhea
Vomiting Blood
None of the Above

Genitourinary

Urinary Loss of Control
Difficulty Urinating
Increased Urinary Frequency
Hematuria
Incomplete Emptying
None of the Above

Musculoskeletal

Muscle Aches
Muscle Weakness
Arthralgias/Joint pain
Back Pain
Swelling in Extremities
None of the Above

Skin

Abnormal Mole
Jaundice
Rash
Itching
Dry Skin
Growth/Lesions
None of the Above

Neurologic

Frequent or Severe Headaches
Migraines
Restless Legs
None of the Above

Endocrine

Fatigue
Increased Thirst
Hair Loss
Increased Hair Growth
Cold Intolerance
None of the Above

Hematologic/Lymphatic

Swollen Glands
Easy Bruising
Excessive Bleeding
None of the Above

Allergic/Immunologic

Runny Nose
Sinus Pressure
Itching
Hives
Frequent Sneezing
None of the Above

Physician's Signature _____

Date _____

Patient Signature _____

Date _____

Respiratory

Cough

Numbness
Seizures
Dizziness