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Review of Systems

Date: _____

Last Name: _____ First Name: _____ DOB: _____

Are you currently experiencing any problems related to the following body systems?

General	YES	NO
Feeling Well	[ ]	[ ]
Appetite Loss	[ ]	[ ]
Chills	[ ]	[ ]
Excessive Crying	[ ]	[ ]
Fatigue	[ ]	[ ]
Fever	[ ]	[ ]
Medication Changes	[ ]	[ ]
Unexplained Weight Loss	[ ]	[ ]
Unexplained Weight Gain	[ ]	[ ]
SKIN	**YES**	**NO**
Bruising	[ ]	[ ]
Change in wart or mole	[ ]	[ ]
Dryness	[ ]	[ ]
Hair Growth	[ ]	[ ]
Hair Loss	[ ]	[ ]
Hives	[ ]	[ ]
Itching	[ ]	[ ]
New Lesions	[ ]	[ ]
Rash	[ ]	[ ]
HEENT	**YES**	**NO**
Blurred Vision	[ ]	[ ]
Corrective Lenses	[ ]	[ ]
Visual Changes	[ ]	[ ]
Decreased Hearing	[ ]	[ ]
Seasonal Allergies	[ ]	[ ]
Oral Ulcers	[ ]	[ ]
RESPIRATORY	**YES**	**NO**
Cough	[ ]	[ ]
Snoring	[ ]	[ ]
Difficulty Breathing	[ ]	[ ]
Shortness of Breath	[ ]	[ ]
Wheezing	[ ]	[ ]
BREAST	**YES**	**NO**
Mass of Lump	[ ]	[ ]
Pain	[ ]	[ ]
Swelling	[ ]	[ ]
Nipple Pain	[ ]	[ ]
Nipple Discharge	[ ]	[ ]
Skin Changes	[ ]	[ ]
CARDIOVASCULAR	**YES**	**NO**
Chest Pain	[ ]	[ ]
Hypertension	[ ]	[ ]
Thrombosis	[ ]	[ ]
GASTROINTESTINAL	**YES**	**NO**
Abdominal Pain	[ ]	[ ]
Black/Tarry Stools	[ ]	[ ]
Bloody Stools	[ ]	[ ]
Change in Bowel Pattern	[ ]	[ ]
Constipation	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]

GI CONTINUED	YES	NO
Diarrhea	[ ]	[ ]
Difficulty Swallowing	[ ]	[ ]
Gas	[ ]	[ ]
Heartburn	[ ]	[ ]
Indigestion	[ ]	[ ]
Jaundice	[ ]	[ ]
Nausea	[ ]	[ ]
Rectal Bleeding	[ ]	[ ]
Vomiting	[ ]	[ ]
Vomiting Blood	[ ]	[ ]
GENITOURINARY	**YES**	**NO**
Vaginal Discharge	[ ]	[ ]
Excessive Menstrual Bleeding	[ ]	[ ]
Bleeding between periods	[ ]	[ ]
Frequency/Urgency of Urination	[ ]	[ ]
Painful Urination	[ ]	[ ]
Night Urination (2 or more times)	[ ]	[ ]
Painful Intercourse	[ ]	[ ]
MUSCULOSKELATAL	**YES**	**NO**
Joint Redness	[ ]	[ ]
Joint Swelling	[ ]	[ ]
NEUROLOGIC	**YES**	**NO**
Headaches	[ ]	[ ]
Seizures	[ ]	[ ]
Migraines with Focal Aura	[ ]	[ ]
PSYCHIATRIC	**YES**	**NO**
Anxiety	[ ]	[ ]
Delusions	[ ]	[ ]
Depression	[ ]	[ ]
Early Awakening	[ ]	[ ]
Hallucinations	[ ]	[ ]
Hypersomnia	[ ]	[ ]
Inability of Concentrate	[ ]	[ ]
Insomnia	[ ]	[ ]
Panic Attacks	[ ]	[ ]
Suicidal Ideation	[ ]	[ ]
Suicidal Planning	[ ]	[ ]
ENDOCRINE	**YES**	**NO**
Excessive Urination	[ ]	[ ]
Hair Changes	[ ]	[ ]
Hot Flashes	[ ]	[ ]
Excessive Thirst	[ ]	[ ]
HEMATOLOGY	**YES**	**NO**
Anemia	[ ]	[ ]
Blood Clots in Legs or DVT	[ ]	[ ]
Easy Bruising	[ ]	[ ]
Enlarged Lymph nodes	[ ]	[ ]
Bleed Excessively (when cut)	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]