REVIEW OF SYSTEMS

NAME_____

DATE_____

Please check yes or no as deemed appropriate regarding the following symptoms

NO	YES	GENERAL	COMMENTS
		Chills	
		Fever	
		Night sweats	
NO	YES	CARDIOVASCULAR	COMMENTS
		Chest pain	
		Irregular heartbeat/palpitations	
		Leg swelling	
NO	YES	SKIN	COMMENTS
		Psoriasis	
		Itchy skin	
		Rash	
		Skin infections	
NO	YES	METABOLIC/ENDOCRINE	COMMENTS
		Diabetes	
		Thyroid problems	
NO	YES	HEENT	COMMENTS
		Blurred vision	
		Dysphagia (Difficulty swallowing)	
		Headache	
		Hearing loss	
		Ringing in ears	
		Vision loss	
NO	YES	GASTROINTESTINAL	COMMENTS
		Abdominal pain	

		Black tarry stools	
		Diarrhea	
		Heartburn	
		Jaundice	
NO	YES	NEUROLOGICAL	COMMENTS
		Difficulty walking	
		Muscle weakness	
		Paresthesia (numbness, tingling feeling)	
NO	YES	PSYCHIATRIC	COMMENTS
		Anxiety	
		Depression	
NO	YES	RESPIRATORY	COMMENTS
		Chest pain (respiratory)	
		Cough	
		Dyspnea (shortness of breath)	
NO	YES	GENITOURINARY	COMMENTS
		Frequent urination	
		Hematuria (blood in urine)	
NO	YES	MUSCULOSKELETAL	COMMENTS
		Back pain	
		Bone/joint symptoms	
		Myalgia (muscle pain)	
		Muscle weakness	
		Neck stiffness	
NO	YES	IMMUNOLOGICAL	COMMENTS
		Asthma	
		Contact dermatitis	
		Environmental allergies	