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REVIEW OF SYSTEMS

Patient's Last Name

Patient's First Name and Middle Initial

Date of Exam

Have you experienced any of the following symptoms *recently*?

	yes	no		yes	no
GENERAL			GASTROINTESTINAL		
Unexplained weight loss			Heartburn		
Night Sweats			Difficulty swallowing		
Excessive Fatigue			Painful swallowing		
Fevers			Vomiting		
ENDOCRINE			Diarrhea		
Tremor			Constipation		
Sweating			Decreased appetite		
Feeling excessively cold			URINARY		
Feeling excessively hot			Frequent urination		
NEUROLOGICAL			Painful urination		
Seizures			Blood in urine		
Fainting			EAR, NOSE, THROAT		
Headaches			Ear pain		
Numbness/Tingling			Hearing loss		
Poor Balance			Ringing in the ears		
Dizziness			Drainage from the ears		
EYES			Runny nose		
Visual changes			Dry nose		
Double Vision			Nosebleeds		
Blind Spots			Nasal blockage		
Eye pain			Mouth sore		
Dry eyes			Toothache		
CARDIOVASCULAR			Sore throat		
Shortness of breath, excessive, with exertion			Snoring		
Palpitations (irregular heartbeat)			RESPIRATORY		
Ankle Swelling			Cough		
Inability to lie flat without becoming short of breath			Coughing up blood		
Leg cramping or heaviness with exertion			Wheezing		
Waking at night short of breath					
HEMATOLOGIC					
Easy bruising					
Excessive bleeding					