

# Review of Systems

Please indicate whether you are experiencing any of the following symptoms:

## Constitutional

<input type="checkbox"/> Yes <input type="checkbox"/> No	Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irritability
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats		

## HEENT

<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nasal Congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever

## Respiratory

<input type="checkbox"/> Yes <input type="checkbox"/> No	Coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Short of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Hurts
<input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB Exposure

## Cardiovascular

<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claudication
<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Palpitations

## Gastrointestinal

<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rectal Bleeding

## Genitourinary

<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased Urine Output	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful Urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Urine Color	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stone Passage
<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mass in Groin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine

## **Metabolic**

Yes  No Hair Loss

Yes  No Heat Intolerance

Yes  No Uncontrolled Hunger

Yes  No Change in Sleep Patterns

Yes  No Tremors

Yes  No Cold Intolerance

## **Neurological**

Yes  No Memory Impairment

Yes  No Visual Changes

Yes  No Vertigo

Yes  No Seizures

Yes  No Loss of Consciousness

Yes  No Light-headed

## **Dermatologic**

Yes  No Acne

Yes  No Skin Lesion

Yes  No Skin Irritation

Yes  No Rash

Yes  No Severe Itching

## **Musculoskeletal**

Yes  No Back Pain

Yes  No Joint Swelling

Yes  No Neck Pain

Yes  No Joint Pain

Yes  No Muscle Weakness

## **Hematologic/Lymphatic**

Yes  No Easy Bleeding

Yes  No Easy Bruising

## **Immunologic**

Yes  No Contact Allergy

Yes  No Food Allergies

Yes  No Seasonal Allergies

Yes  No Environmental Allergies